

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10153

38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Oct 3, 1948

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, MarylandHow long in hospital or institution? Since Oct-5, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 407 N. Duncan St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Annie E. Affayroux7. Birth date of deceased (mo., day, yr.) January 4, 1883 B. (c) If alive, give age 64 years8. AGE: Years 65 Months 9 Days 20 If less than one day hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Refined machinist11. Industry or business John F. Affayroux12. Name Baltimore, Md.13. Birthplace Baltimore, Md.14. Maiden name Mary C. McCeran15. Birthplace Baltimore, Md.16. Informant personal history- hospital recordsAddress Eudowood Sanatorium, Towson 4, Maryland17. Burial Date thereof Nov. 2-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Baltimore CenLocation North Ave. + Gay St.18. Funeral director John A. MillerAddress 2334 Jefferson St.19. 10-29-48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948 at 8:40 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1948 to October 29 1948 and that I last saw him alive on October 25 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. F. Bridges

M. D. or author

Address Towson 4, MarylandDate signed 10-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10154

Reg. Dist. No. 39

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Sept 10, 1948

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, MarylandHow long in hospital or institution? Since Sept 10, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson 4, Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. Eudowood Sanatorium3585 Cascade Avenue
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Charles Frank Alder

3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife unknown6. (c) If alive, give age Birth Older7. Birth date of deceased (mo., day, yr.) November 12, 18868. AGE: Years 62 Months 10 Days 19 If less than one day9. Birthplace Baltimore County
(Town, county, and state)10. Usual occupation Waiter

11. Industry or business

12. Name Charles Alder13. Birthplace Baltimore County14. Maiden name Christians Kelly15. Birthplace Baltimore Md16. Informant personal history- hospital recordsAddress Eudowood Sanatorium, Towson 4, Maryland17. Burial Date thereof Oct 4-1948
(Burial, cremation, or removal) Which? (month) (day) (year)Cemetery or crematory WoodlawnLocation Baltimore Co., Maryland18. Funeral director Burgee Funeral HomeAddress 3631 Falls Road, Baltimore 1119. Oct 7 19 48 H. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 10 19 48 at 1:45and that I last saw him alive on Sept 30 19 48

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. A. BridgesAddress Towson 4, Md.Date signed 10-1-48

~~Birth~~ **DEATH**
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 10155

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Balto
 City or town Inner Station
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
142 Barbours Ct
 Length of mother's stay in County 2 yrs
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Baltimore
 City or town Inner Station
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 142 Barbours Ct.
 (If RURAL give LOCATION)

3. Name of child none
 5. Sex m

4. Date of birth 10-23-1948 Hour 11:30 P M.
 7. No. of weeks pregnancy 22 weeks

FATHER OF CHILD
 8. Full name Levy Alston
 9. Color c 10. Age at time of this birth 23 yrs.
 11. Usual occupation laborer

MOTHER OF CHILD
 12. Full maiden name Fannie Lee Alston
 13. Color c 14. Age at time of this birth 20 yrs.
 15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1
 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 1

17. Did child die before labor? no During labor? no
 18. Pregnancy, complications of none

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

19. Labor: (a) Complications of Premature
 (b) Induced? no

(a) Fetal causes Premature
 (b) Maternal causes none

20. (a) Was there an operation for delivery? none
 (b) State all operations, if any none
 (c) Did child die before operation? none
 During operation?

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Robert L. Johnson
 (Specify if M. D., midwife, or other)

Address 427 W. Baltimore

23. (a) Burial (b) Date thereof Oct 25 1948
 (Burial, cremation or removal) (month) (day) (year)
 (c) Cemetery or crematory Mt. Calvary Cem

25. (a) 10/25/48 (b) A. W. Hefst
 (Date rec'd by registrar) (Registrar)

24. (a) Funeral director Mrs. R. A. Elliott's Df.
 (b) Address 1129 N. Caroline St

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Child
lived
20
minutes

V. S. A10

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10156

34

1. PLACE OF DEATH:

County Baltimore
 City or town Upper Co. P.O.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Holiday House
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town 8531 Chestnut Oak Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Towson
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Irvin H. Baker

3. (b) Social Security Number

190-05-7868

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Ira Baker
 7. Birth date of deceased (mo., day, yr.) August 10, 1901
 8. AGE: Years 47 Months 2 Days 10 It less than one day _____ hrs. _____ min.
 6.(c) If alive, give age _____ years

9. Birthplace Rockwood, Penna.
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business Self

12. Name Harry M. Baker

13. Birthplace Somerset, Penna.

14. Maiden name Unknown

15. Birthplace "

16. Informant Irvin C. Baker

Address 8531 Chestnut Oak Rd., Towson, Md.

17. Removal Date thereof Oct. 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Shank Funeral Home

Location Windber, Penna.

18. Funeral director John Burns' Sons

Address Towson, Maryland

19. Oct. 26 19 48 Mary B. Ehline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 19 48 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 48, to Oct 20 19 48, and that I last saw him on Oct 20 19 48

Immediate cause of death acute alcoholism DURATION 3 wks.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None

_____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

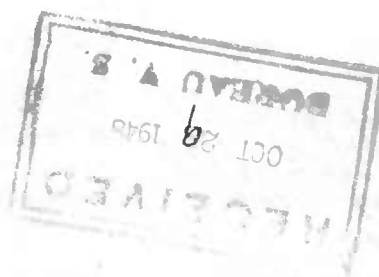
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? med.

23. SIGNATURE D. D. Caples, M.D. Exam.

Address Reisterstown, Md. Date signed 10-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10157

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore Middleboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Miles Rd., Middleboro

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Baltimore Middleboro
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 16 - Box 261 Miles Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary B. Baker

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

James W. Baker

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Mar. 24 - 1875

8. AGE:

Years

Months

Days

If less than one day

73 6 27 hrs. min.

9. Birthplace

Balto., Md.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Charles Burgan

12. Name

Balto., Md.

13. Birthplace

Not known

14. Maiden name

Not known

15. Birthplace

Mary B. Albright

16. Informant

Box 247 Miles Rd., MiddleboroBurial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 25 - 48
(month) (day) (year)

Cemetery or crematory

Western Cemetery

Location

Edmondson Ave.

18. Funeral director

John H. MillerAddress 2334 Jefferson St.19. 10/22 19 48 AW Hedrick
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 21 1948 at 8:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10 - 10 1947 to 10 - 21 1948and that I last saw her alive on 10 - 21 - 48 1948

Immediate cause of death

Primary leukemia

DURATION

Due to Myocardial Cardia -
Vasculous disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis Vogel J. M. D.
M. D. or other
Address 2301 E. Monument St. Date signed 10-22-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10158

Reg. Dist. No. 41

1. PLACE OF DEATH

County BaltimoreCity or town Sparsburg Pt. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town FORT HOWARD - BALDWIN
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. Box - 24
(If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

JAMES M. BOHON

3. (b) Social Security Number

4. Sex M. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced M.6. (b) Name of husband or wife Rachel C. Bohon7. Birth date of deceased (mo., day, yr.) October 15, 19048. AGE: Years 43 Months 11 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace West Virginia
(Town, county, and state)10. Usual occupation Welder11. Industry or business Bethlehem Steel Co.12. Name Jefferson D. Bohon13. Birthplace W. Va.14. Maiden name Grace Piercy

15. Birthplace

16. Informant Mrs. Rachel C. BohonAddress Lodge Farm Rd., Sparsburg Point, Md.17. Burial Date thereof Oct. 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Elkins, West Virginia18. Funeral director Roland L. FischerAddress 2112 Dundalk Ave.19. Oct 4 19 48 William M. Kelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 19 48 at 3:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

① Crushed Rt. Chest & Abdomen② TRAUMATIC AMPUTATIONDue to RT. HANDDue to Ran over by overhead crane

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/3/48Where did injury occur? Beth. Steel Co. - Sp. Pt. Baldwin Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) IndustryMeans of injury Ran over by crane & injured at work? Yes

23. SIGNATURE

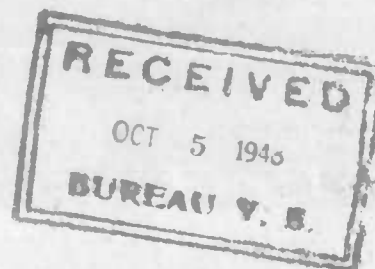
Wm. B. Davis M.D.
Address Dundalk, Md. Date signed 10/3/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition of
date of death shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10159

CERTIFICATE OF DEATH

Reg. Dist. No. 35

FILE No. G 117 OCT 20 1948

1. PLACE OF DEATH:

County Baltimore

City or town Parkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore

City or town Parkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) if veteran, name war _____

3. (a) FULL NAME

NANNIE C. BORNEMAN

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Philip A. Borneman

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) MARCH 12, 1870

8. AGE: Years 78 Months 6 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND LINE, MD
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name LEVI PEARCE

13. Birthplace MARYLAND LINE, MD

14. Maiden name LYDIA LEIGH

15. Birthplace MARYLAND LINE, MD

16. Informant Mrs. Egan Wheeler

Address Parkton, Ind

17. Burial Date thereof Oct. 13-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CLYNNALRIA

Location MONKTON, MD

18. Funeral director Howard S. Markblie

Address White Hall, Ind

19. Oct 12, 1948 (Date rec'd by registrar)

20. Monkton, Ind (Address of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1948 at 9:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948 to Oct 10, 1948 and that I last saw him alive on Oct 10, 1948

Immediate cause of death Coronary Thrombosis DURATION 4 days

Due to Chronic Myocarditis 5 yrs

Due to Arteriosclerosis

Other conditions 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

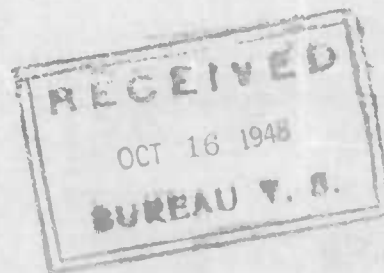
23. SIGNATURE Paul D. Shant M.D. or other _____

Address Shrewsbury, Pa Date signed 10-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10160

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 232 Westshire Road
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

IDA BELLE BOUCHER

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Emile G.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 18898. AGE: Years Months Days If less than one day
59 1 8 hrs. min.9. Birthplace York, Pa.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Kirk Lerew13. Birthplace Pa.14. Maiden name Unknown15. Birthplace Unknown16. Informant Emile BoucherAddress 232 Westshire Road17. Burial Date thereof 11/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New CathedralLocation Baltimore, Md.18. Funeral director William Cook, IncAddress 1 217 St. Paul St/19. 11/2 XP A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1948 19 9:30 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1948 to Oct 1948 and that I last saw her alive on Oct 31 19 48Immediate cause of death Ventricular fibrillation DURATION 10 min.Due to Coronary sclerosis 2 yrsDue to Hypertension & Cardiovascular disease 5 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Douglas Robinson M. D. or otherAddress 2835 Juy 44, Falls Church Date signed 11/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10161

Reg. Dist. No. 39

1. PLACE OF DEATH:

County *Baltimore*City or town *Monkton*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *Lifetime*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Monkton*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war *None*

3. (a) FULL NAME

Milton A. Brewer

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Grace (nee Palmer)

7. Birth date of deceased (mo., day, yr.)

? abt 1979

8. AGE:

69

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Balto. Co. Md.
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mr. Frank Keen

Address

Colleysville, Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Nov. 3, 1948
(month) (day) (year)

Cemetery or crematory

Fosters

Location

Hersford, Monkton P.O., Md

18. Funeral director

London on Brooks

Address

*Sparks, Md*19. *Nov 3, 1948*
(Date rec'd by registrar)*Bruce Price*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Oct. 31* 19 *48* at *3:00* P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ to _____

and that I last saw him _____ alive on _____

Immediate cause of death

Illegal on arrival
chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

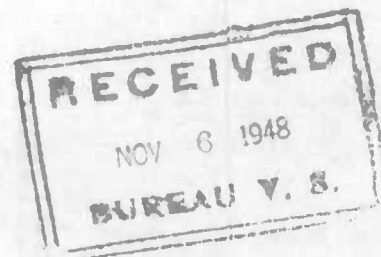
Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

*A. M. France*Address *Parthia, Ind.* Date signed *11/1/48*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10162

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 years, 11 mos., 20 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 14 years, 11 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)Street No. 888 W. Baltimore St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EMMA E. BRINGMAN (Bringham)

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1872

8. AGE:

Years

Months

Days

If less than one day

7614

hrs.

min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Domestic

MOTHER FATHER

12. Name

William Bringman

13. Birthplace

Germany

14. Maiden name

Charlotte Brandauer

15. Birthplace

Germany

16. Informant

Hospital records

Address

Catonsville 28, Md.

17

Burial
(Burial, cremation, or removal, Which?)

Date thereof

Oct 25-48
(month) (day) (year)

Cemetery or crematory

Landon Park

Location

18. Funeral director

Address

19.

10/23/1948

(Date rec'd by registrar)

19.

R.W.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22, 1948 at 12 N.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 2, 1933 to October 22, 1948and that I last saw him er. alive on October 22, 1948

Immediate cause of death

Acute coronary occlusion

DURATION

5 minutesDue to Degenerative myocardial disease Indefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isadore Tuerk, M.D.

M. D. or other

Address

Catonsville-28, Md.Date signed 10-23-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10163

Reg. Dist. No. 30

1. PLACE OF DEATH:

County **Baltimore**City or town **Catonsville**
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? **since June 15, 1948**

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? **since June 15, 1948**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Baltimore**City or town **Baltimore City- Seton Inst.**
(If outside city or town limits, write RURAL and give nearest town)Street No. **1208 Ebor St.**
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Sarah Ann BROWNE

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M6. (b) Name of husband or wife **unknown**

7. Birth date of deceased (mo., day, yr.)

Sept. 18, 1880

6. (c) If alive, give age years

8. AGE:

Years **68**Months **0**Days **21**

It less than one day

hrs. min.

9. Birthplace **Ireland**

(Town, county, and state)

10. Usual occupation **none**

11. Industry or business

MOTHER FATHER

12. Name **John Cox**13. Birthplace **Ireland**14. Maiden name **Sarah Ann McGuire**15. Birthplace **Ireland**16. Informant **Hospital records**Address **Spring Grove State Hospital**17. **Burial** Date thereof **Oct 13, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **Cathedral**Location **Baltimore**18. Funeral director **Rita W. Deibel**Address **900 East Biddle St**19. **Oct 11** 19 **48** **A. W. Hedrick**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 9, 1948** 19 at **3:25 PM**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 15th, 1948** 19 to **Oct. 9, 1948**and that I last saw her alive on **Oct. 9, 1948** 19

Immediate cause of death

Terminal pneumonia

DURATION

2 weeksDue to **Huntington's Chorea****indef**Due to **Generalized Arteriosclerosis****indef**Due to **Hypertensive E-V dis.****indef**

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Abraham M. Schneidmuhl, M.D.Address **Spring Grove Hospital** Date signed **10/9/48**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

10164

170C

1. PLACE OF DEATH

County Balto.City or town Brashear
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Louise Bunk

7. Birth date of deceased (mo., day, yr.)

Apr. 21, 1871

8. AGE:

Years

77

Months

6

Days

3

If less than one day

hrs. min.

9. Birthplace

Penn.
(Town, county, and state)

10. Usual occupation

Timber & Saw mill work

11. Industry or business

Thomas Bunk

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. (Burial, cremation, or removal. Which?)

18. Funeral director

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

216-28-0952

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 24, 1948 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw him alive on... 19...

Immediate cause of death

DURATION

Compound fracturefront skull completelycrushedfracture of left wristleft ankle.

Other condition

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicideDate of Oct 24, 1948

Where did injury occur?

Brashear Balto Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury AutoInjured at work? 2

23. SIGNATURE

Dr. J. M. Carmona, M.D.Address Balto. C. Dental 22Date signed 10/24/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *3*

10165

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 32 Winters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

KYZIAH BURTON

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Frank Burton 6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) July 4, 1874
8. AGE: Years 74 Months 3 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Calvert Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name Isaac Coates
13. Birthplace Md.
MOTHER 14. Maiden name Elizabeth Blake
15. Birthplace Md.

16. Informant Mr. Frank Burton
Address 32 Winters Lane

17. Burial 10-8-48 Date thereof (month) (day) (year)
(Burial, cremation, or removal, Which?)
Cemetery or crematory Western Star Cem.
Location Catonsville Balto., Co., Md.

18. Funeral director Mrs. Frances A. Hemsley
Address 578 W. Biddle St

19. 10/7 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5th 1948 at 3:40 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-12-1948 to 10-5-1948
and that I last saw her alive on 10-5-48

Immediate cause of death Acute Myocarditis DURATION 2 days
Hyperthyroidism
Cardiac disease ?
Due to _____
Due to _____
Other conditions Obesity
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury _____ Injured at work?

23. SIGNATURE P. F. Maloney MD M. D. or other
Address Catonsville Md Date signed 10/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

10165

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 621 W. Barre St.
(If rural, give LOCATION)
2.(a) If veteran, name war WW-I

3. (a) FULL NAME

HARVEY M. CARTER

3. (b) Social Security Number

214-22-4195

4 Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 3-1-88 6.(c) If alive, give age years

8. AGE: Years 60 Months 7 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Charles Carter

13. Birthplace Maryland

14. Maiden name Mary ?

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland

17. Burial Burial Date thereof 10/29/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
Location Wm. Jackson

18. Funeral director Baltimore, Maryland
Address

19. Oct 27 19 48 A. B. French
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 19 48 at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 19 48 to October 26, 19 48 and that I last saw him alive on October 26, 19 48.

Immediate cause of death CEREBRAL INFARCTS

	DURATION
Due to <u>Arteriosclerosis and Hypertension</u>	<u>1 week</u>
Due to <u> </u>	<u> </u>
Other conditions <u>None</u>	<u> </u>

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?)

Means of injury A.B. French Injured at work?

23. SIGNATURE A.B. French, M.D. M. D. or other

Address VAH Fort Howard, Md. Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 33

10167

85

1. PLACE OF DEATH:

County... Baltimore
 City or town... Quinns Mills
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr. 5 mo. 5 days
 Hospital, institution, or street address where death occurred:
Pascowald State Training School
 How long in hospital or institution? 1 yr. 5 mo. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Rural Hagastown RD 205
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Ottie Anne Clark

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) September 16, 1934

8. AGE: Years Months Days If less than one day

14 1 15' _____ hrs. _____ min.9. Birthplace Hagastown Washington Maryland
(Town, county, and state)10. Usual occupation None

11. Industry or business _____

12. Name Samuel W. Clark13. Birthplace Maryland14. Maiden name Fannie Dobson15. Birthplace Virginia16. Informant Rounded State School BoardAddress Quinns Mills Maryland17. Burial Date thereof Nov. 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ChesvilleLocation Washington Co18. Funeral director William H DowneyAddress 2917 Frederick St Hagastown Md19. 11-1-1948 MARY B. E. Line
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 10 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 26, 1947 to October 31, 1948and that I last saw her alive on October 31, 1948

Immediate cause of death _____

Acute edema of lungs 2 1/2 hrs.Due to Serial Epilepsy 3 hrs.

Due to _____

Other conditions marked Dorsal Scoliosis life?Since admission

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work? _____

Signature Dr. H. M. Clinton, M.D.Address Quinns Mills, Md. Date signed 11/1/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10168

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

301 E. Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 301 E. Street
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John T. Colbert

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Elizabeth Colbert

7. Birth date of

deceased (mo., day, yr.)

August 5, 1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72220

hrs.

min.

9. Birthplace

Boston, Mass.

(Town, county, and state)

10. Usual occupation

Watchman

11. Industry or business

Pittsfield Steel Co.

12. Name

Thomas Colbert

13. Birthplace

Ireland

14. Maiden name

Margaret

15. Birthplace

Ireland

16. Informant

Mrs. Elizabeth Colbert

Address

301 E. St., Sparrows Point

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month), (day) (year)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern Blvd.

18. Funeral director

Poland L. Fisher

Address

2112 Dundalk Ave.

19.

(Date rec'd by registry)

Oct 27, 1948 Dawson L. Harber

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 17, 1948 to Oct 25, 1948and that I last saw him alive on Oct 25, 1948

Immediate cause of death

Cardio-respiratory failure 2 day
Chronic Arterio-Sclerotic 5 yrs
heart disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Dawson L. Harber M.D.
Sparrows Point Md. Date signed 1/27/48

M. D. or other

RECEIVED
JUL 1 1948
BUREAU A. S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 110 NOV 12 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Larry Hall Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 6525 St. Helena Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Howard Coleman

3. (b) Social Security Number

4. Sex

m.

5. Color or race

w

6. (a) Single, married, widowed, or divorced

m6. (b) Name of husband or wife Bessie E. Coleman

7. Birth date of

deceased (mo., day, yr.)

June 23, 1872

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7620320

hrs.

min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Watchman11. Industry or business Intercoastal Paint Co.12. Name Francis Coleman

13. Birthplace

14. Maiden name Mary

15. Birthplace

16. Informant Mrs. Bessie E. ColemanAddress 6525 St. Helena Ave. Dundalk17. Burial
(Burial, cremation, or removal. Which?)Date thereof Oct. 16, 1948
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern Blvd.

18. Funeral director

Roland S. Fisher

Address

2112 Dundalk Ave.19. Oct 15 - 48
(Date rec'd by registrar)John B. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-121948

to

10-131948and that I last saw him alive on 10-13-48 1948

Immediate cause of death

Carcinoma of the prostate with metastasis to the right thigh.

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eugene J. Newy M.D.

M. D. or other

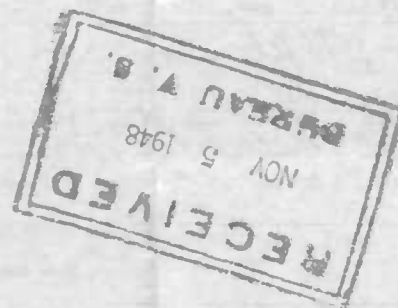
Address

Dundalk, Md.Date signed 10-16-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10170

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Landsdown Ave.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

141 Elizabeth Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Landsdown Ave.
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 Elizabeth Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Corea V. Gordon

3. (b) Social Security Number

no.4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife George W. Gordon7. Birth date of deceased (mo., day, yr.) May 17-1879 6. (c) If alive, give age dec years8. AGE: Years 69 Months 4 Days 12 If less than one day9. Birthplace Baltimore Md
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Elizabeth Porter13. Birthplace North Carolina14. Maiden name Mary Dubuque15. Birthplace North Carolina16. Informant Miss Hazel M. PiquettAddress 141 Elizabeth Ave. Landsdown17. Burial Date thereof Nov 29 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lanham ParkLocation Woodhams and18. Funeral director Dr. Blumenthal & SonAddress 300 Eastview Place19. Nov 29 1948 Registrar G. Kieffer
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29-1948 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Acute Cardiac failure

Due to

Coronary vascular disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. Kieffer Kaplan
M. D. or other Evan BellAddress 1010 Linden Date signed Nov 29 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 125 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 125 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1219 Madison Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-2

3. (a) FULL NAME

CHARLES COWAN

3. (b) Social Security Number

213-10-5226

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 1-2-1910
 8. AGE: Years 38 Months 9 Days 23 It less than one day hrs. min.

9. Birthplace High Point, N. C.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER
 12. Name Thomas Cowan
 13. Birthplace North Carolina
 14. Maiden name Emma Tip
 15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. H. sp.
 Address Fort Howard, Maryland

17. Burial Date thereof 10/29/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
 Location

18. Funeral director Charles R. Law
 Address 802 Madison Ave., Balto., Md.

19. October 28 48 A. W. French
 (Date rec'd by registrar) 19 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 19 48 at 3:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 22, 19 48 to October 25, 19 48
 and that I last saw him alive on October 25, 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION 7 Mos

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?)

Means of injury Injured at work?

23. SIGNATURE A. B. French M. D. or other

ARTHUR FRENCH, M.D.
 Address VAH, FORT HOWARD, MD. Date signed 10-26-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10171

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10172

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

House in the Pines

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 W. Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara Snowden Culbreth

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female

White

Widow

6.(b) Name of husband or wife Richard S. Culbreth

7. Birth date of deceased (mo., day, yr.) July 9, 1858
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
90 2 25 hrs. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name John Thos. Snowden

13. Birthplace A. A. Co. Md.

14. Maiden name Mary W. Schwar

15. Birthplace Unknown

16. Informant Mrs. Wilton Snowden, Jr.
12 E. 33rd St. Baltimore Md.
Address

17. Burial Date thereof 10/7/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Greenmount

Location Baltimore, Md.

18. Funeral director Wm. J. Tickner & Sons, Inc.

Address North & Pennsylvania Ave. Balto. Md.

19. 10/7 48 A. W. Neduck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

30

20. DATE OF DEATH October 4, 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27, 1948 to October 4, 1948 and that I last saw her alive on October 2, 1948

Immediate cause of death Myocardial Insufficiency DURATION 2 mo.

Due to Generalized arteriosclerosis 20 yr. (?)

Due to

Other conditions Senile dementia 10 yr. (?)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. K. Gallager, M.D. M. D. or other

Address 6209 Federal St. Balto. Md. Date signed 10-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10173

Reg. Dist. No. 44

I. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 42 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia CountyCity or town St. Mary's
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. # 2
(If rural, give LOCATION)2.(a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

BURL E. CUNNINGHAM

3. (b) Social Security Number

235-22-3535

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) 2-16-18

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
30 7 25 hrs. min.9. Birthplace St. Mary's, W. Va.
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name Thomas Cunningham13. Birthplace West Virginia14. Maiden name Elvie Boley15. Birthplace St. Mary's, W. Va.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Removal Oct. 12, 1948
(Date of removal or removal. ~~XXXX~~) (month) (day) (year)

Cemetery or crematory

Location Howard Blight
6009 Harford Rd., Balto., Md.18. Funeral director Rattencutter Funeral HomeAddress St. Mary's, West Virginia19. Oct 11 19 48 Sharon T. Harber
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 4:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1948 to October 11, 1948 and that I last saw him alive on October 11, 1948Immediate cause of death Subacute Glomerulonephritis 9 mos. DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy result: Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGHAddress VAH, Ft. Howard, Md. Date signed 10-11-48

RECEIVED
OCT 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10174

43

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Belair Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

LILLIE E. DEAVER

3. (b) Social Security Number

4. Sex..... female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... widow

6.(b) Name of husband or wife..... William O. Deaver

7. Birth date of deceased (mo., day, yr.)..... Jan. 2nd, 1885
 6.(c) If alive, give age..... years

8. AGE: Year..... 63 Month..... 9 Day..... 24
 If less than one day..... hrs. min.

9. Birthplace..... Grange, Baltimore County
 (Town, county, and state)
 10. Usual occupation..... at home

11. Industry or business

12. Name..... Benjamin F. Glaspy
 13. Birthplace..... Baltimore County, Md.

14. Maiden name..... Mary A. Taylor
 15. Birthplace..... Baltimore County, Md.

16. Informant..... Mrs. J. Clifford Sener
 Address..... Perry Hall, Md.

17. burial..... 10/29/48
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)
 Cemetery or crematory..... Oak Lawn
 Location..... Baltimore, Md.

18. Funeral director..... Lassarahn Funeral Home
 Address..... 7401 Belair Rd.

19. Oct 26 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 26th, 1948, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Sept. 12, 1948, to Oct 26, 1948
 and that I last saw him alive on Oct. 25, 1948

Immediate cause of death.....

Congestive Heart Failure

DURATION

1 day

Due to.....

Cardio - Vascular
 Hypertensive Disease
 Arteriosclerosis

7 years

7 years

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Michael J. Danach M.D.
 M. D. or other

Address..... W. Overman Ave Date signed..... 10/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

10175

1. PLACE OF DEATH:

County Balta

City or town Elgate
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

401 Oak Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balta

City or town Elgate
(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 Oak Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elmer Dietrick

3. (b) Social Security Number

213-03-7251

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Elin Dietrick

nee Kramer 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1896

8. AGE: Years 51 Months 11 Days If less than one day hrs. min.

9. Birthplace Balta, md.
(Town, county, and state)

10. Usual occupation Printer

11. Industry or business

12. Name Frederick Dietrick

13. Birthplace Balta, md.

14. Maiden name Margaret Sweetzer

15. Birthplace Balta, md.

16. Informant Mrs. Elin Dietrick (wife)

Address 401 Oak Ave.

17. Burial Date thereof 10/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Oak Lawn

Location Eastern Ave. Essex 21, md.

18. Funeral director John J. Connolly

Address 418 Eastern Ave. Essex 21, md.

19. Oct. 4 19 48 John J. Connolly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1948 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948 to Oct. 2, 1948 and that I last saw h. l.m. alive on Oct. 2, 1948.

Immediate cause of death Pulmonary edema.
Heart Failure
Hypertension

DURATION
2 days
1 wk.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maxwell Edmund

Address 417 1/2 Eastern Ave. Essex M. D. or other

Date signed 10-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10176

1. PLACE OF DEATH:

County..... Balto.

City or town..... Rockdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
8106 Liberty Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Rockdale
(If outside city or town limits, write RURAL and give nearest town)Street No..... 8106 Liberty Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

FRANK J. DOETZER, Sr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife..... Mary E. Doetzer

7. Birth date of

deceased (mo., day, yr.)

6.(c) If alive, give age..... years
Dec. 7, 1874

8. AGE:

Years

Months

Days

If less than one day

73

10

12

.....hrs.

.....min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Harness Maker

11. Industry or business

FATHER

12. Name.....

John Doetzer

13. Birthplace.....

Germany

MOTHER

14. Maiden name.....

Margaret Wagner

15. Birthplace.....

Germany

16. Informant.....

Mr. Frank J. Doetzer

Address.....

2514 Strathmore Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof.....

10/23/48

(month) (day) (year)

Cemetary or crematory.....

Holy Redeemer Cem.

Location.....

Balto., Md.

18. Funeral director.....

WM. J. TICKNER & SONS

Address.....

Balto., Md.

19.

(Date rec'd by registrar)

10/21

19 48

R. W. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct. 19, 19 48, at 1:40a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 11, 19 48, to Oct. 19, 19 48
and that I last saw him alive on Oct. 18, 19 48

Immediate cause of death.....

Congestive heart failure

Due to.....

Hypertension

Due to.....

Arterio-sclerotic heart disease

Other conditions.....

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

4710 Liberty St. Date signed 10/19/48
M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 0 mos., 8 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution 0 yrs., 0 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 834 Washington Blvd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

William Dofflemeyer

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

December 31, 1896

8. AGE:

Years

Months

Days

If less than one day

51

9

12

hrs. min.

9. Birthplace

Dickesville, Maryland
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Harris Dofflemeyer

13. Birthplace

Virginia

14. Maiden name

Annie Kerrigan

15. Birthplace

Ireland

16. Informant

William Dofflemeyer

Address

834 Washington Blvd., Balto., Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 15, 1948
(month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

2930 Fred Ave., Balto., Md.

18. Funeral director

John J. Cowan Sons

Address

901 Hollins St., Balto., Md.

19. 10/12/48

(Date rec'd by registrar)

19

Helen R. Mayer

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1948 10:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 4, 1948 to October 12, 1948
 and that I last saw him alive on October 12, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

3 mos.Due to Tubercle bacilli

Due to _____

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation.

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Stewart S. Shaffer M.D.
M. D. or otherAddress Mt. Wilson, Md. Date signed 10/12/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 44

10178

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 58 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
 How long in hospital or institution? 58 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Landsdowne
 City or town Landsdowne
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2013 Sulphur Spring Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, home war WW-I

3. (a) FULL NAME

AUGUST M. DONESKI (Doniecki)

3. (b) Social Security Number

218-05-6367

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth data of deceased (mo., day, yr.) 8-29-1892 8.(c) If alive, give age years
 8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>1</u>	<u>29</u>	<u>hrs. min.</u>

9. Birthplace Baltimore, Maryland
 (town, county, and state)
 10. Usual occupation Contractor Foreman
 11. Industry or business
 12. Name Conrad Doneski
 13. Birthplace Poland
 14. Maiden name Francis Ostrowski
 15. Birthplace Poland
 16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Burial Date thereof 11-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Rosary
 Location Baltimore, Maryland
 18. Funeral director George A. Weber
 Address 705 S. Ann St., Balto., Md.

19. Oct 29, 48 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 19 48 at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 31, 19 48 to October 28, 19 48
 and that I last saw him alive on October 28, 19 48

Immediate cause of death Carcinoma of liver DURATION Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH M.D. Chief Prob. Secy
 Address VAH, Ft. Howard, Md. Date signed 10-28-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Lansdowne Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
At Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lansdowne Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2011 Sulphur Spring Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Conrad Doniecki

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of ~~husband~~ wife Frances

7. Birth date of deceased (mo., day, yr.) December 18th 1858 ? 6. (c) If alive, give age years

8. AGE: Years 89 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Baltimore & Ohio Railroad

12. Name August Doniecki

13. Birthplace Poland

14. Maiden name Johanna &

15. Birthplace Poland

16. Informant Mrs. Maryanna A. Grabowski (Daughter)

Address 2017 Sulphur Spring Road

17. Burial Date thereof 10-12-48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery Holy Rosary

Location Baltimore Co. Md.

18. Funeral director George A. Weber

Address 705 South Ann Street

19. 10/11 19 48 921 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th 19 48 at 7:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 48 to Oct 9 19 48.

and that I last saw him alive on Oct 9 - 48 19 48.

Immediate cause of death Chronic Myocarditis DURATION 10 yrs

Due to arteriosclerosis 10 yrs

Due to structural changes 10 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op.

Autopsy results None PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. J. D. M. D. or other

Address 1711 Selma St Date signed Oct 11-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10180

43

1. PLACE OF DEATH:

County Baltimore
 City or town Fullerton Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Fullerton
 City or town Fullerton Md
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Alice E Elizabeth Dorsey

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife George

7. Birth date of deceased (mo., day, yr.) Feb 5, 1901
 6.(c) If alive, give age _____ years

8. AGE: Years 47 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Williams13. Birthplace Md14. Maiden name Marie Williams15. Birthplace Md16. Informant George DorseyAddress Fullerton Md.17. Burial Date thereof Oct 5/49

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Asbury CemeteryLocation Louise Ind.18. Funeral director Mrs. Pitt J. Elliott, Dpt.Address 1129 N. Carolina19. 10/4 48 Edw Hedrick

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 48 at 12:46 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 48 to Oct 2 19 48and that I last saw him/her alive on Oct 1 19 48Immediate cause of death Carcinosis of Liver

DURATION

1 yr

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Edw Hedrick M. D. or otherAddress Edgewood Md Date signed Oct 2 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10181

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 711 S. Ann Street
(If rural, give LOCATION)2(a) If veteran, name war VV-I

3. (a) FULL NAME

FRANK DUDECK

3. (b) Social Security Number

217-07-6046

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mary Dudeck6. (c) If alive, give age 52 years

7. Birth date of

deceased (mo., day, yr.) 3-27-94

8. AGE:

Years

Months

Days

If less than one day

54621

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business

FATHER

12. Name George Dudeck13. Birthplace Austria

MOTHER

14. Maiden name Unknown MARY GLINSKI15. Birthplace Austria18. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-22-48
(month) (day) (year)Cemetery or crematory St. Stanislaus CemeteryBaltimore, MarylandLocation George A. Weber18. Funeral director George A. WeberAddress 705 So. ANN ST Baltimore, Md.19. 10-20 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 19 48 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 16, 1948 to October 18, 1948and that I last saw him alive on October 18, 19 48

Immediate cause of death

Metastatic carcinoma, liver

DURATION

UnknownDue to Carcinoma of rectum1 Yr.

Due to

Other conditions Cerebral thrombosis36 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.C. MANAUGH, M.D. Chief Prob. Sec.Address VAH, Ft. Howard, Md. Date signed 10-19-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10182

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since Sept. 22, 1917

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? since Sept. 22, 1917

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph DUNN

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Cecilia Dunn

7. Birth date of deceased (mo., day, yr.) 1876 6. (c) If alive, give age ? years

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual occupation merohant

11. Industry or business _____

12. Name unknown

13. Birthplace Russia

14. Maiden name unknown

15. Birthplace Russia

16. Informant hospital records

Address Spring Grove Hospital, Catonsville-28

17. Funerals Date thereof 10-31-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory B'har Israel

Location Southern Ave

18. Funeral director Jack Lewis, Inc

Address 2160 Entaw Place

19. 10-30 1948 VE. Harry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1948 19____ at 4:55 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26, 1948 to Oct. 30, 1948 and that I last saw him alive on October 30, 1948

Immediate cause of death
Terminal pneumonia
Cardio-vascular-renal disease
XXX anemia

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, publc place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE Abraham M. Schneidmuhl, M.D.
Address Spring Grove Hospital Date signed 10/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10183

Reg. Dist. No. 35

1. PLACE OF DEATH:

County BaltimoreCity or town White Hall Ind
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County BaltimoreCity or town White Hall
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN RUSSELL EDIE

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife May Jean Edie6. (c) If alive, give age 56 years

7. Birth date of

deceased (mo., day, yr.) Sept. 9 - 1892

8. AGE:

Years 56Months 1Days 4

If less than one day

hrs. min.

9. Birthplace

Harford Co Ind
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

FATHER

12. Name

William C. Edie

13. Birthplace

Harford Ind

MOTHER

14. Maiden name

May A. Thompson

15. Birthplace

York Co Pa

16. Informant

Mr. G. Russell Edie

Address

White Hall Ind

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Oct. 16 - 1948
(month) (day) (year)

Cemetery or crematory

Stratstown, Pa

Location

Howard S. Marklin

18. Funeral director

Address

White Hall Ind

19. Oct. 15,

(Date rec'd by registrar)

19 48Mrs. Howard S. Marklin

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 13 19 48 at 10:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1947 to Oct. 13 48and that I last saw h. 17 alive on Oct. 13 19 48

Immediate cause of death

Carcinoma of lung

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

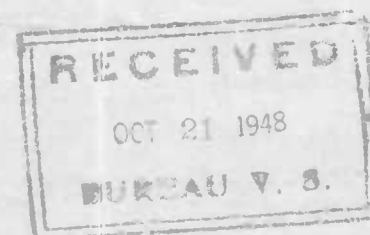
23. SIGNATURE

A. M. France

M. D. or other

Address White Hall Ind Date signed 10/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10184

Reg. Dist. No. 50

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Poplar Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Onondaga

City or town Syracuse

(If outside city or town limits, write RURAL and give nearest town)

Street No. 227 Kirk Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Bertha Frances Edson

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife George Edson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8 1879

8. AGE:

Years

Months

Days

If less than one day

68

11

1

hrs.

min.

9. Birthplace Connecticut

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Thomas Williams

13. Birthplace Conn

14. Maiden name Unknown

15. Birthplace Conn

16. Informant Mrs. John S. Edson

Address Poplar Ave. Catonsville, Md

17. Burial Date thereof 10-12-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Stafford Springs

Location Stafford Springs Conn.

18. Funeral director F.C. Higinbotham

Address Ellicott City, Md.

19. 10-10-48 J.H. Harry

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 48 at 5:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Coronary occlusion

Due to

Ischemic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. Kieffer deputy

M. D. or other

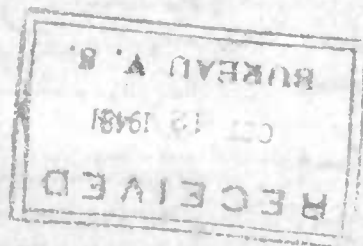
Address 1010 Leida ave Date signed Oct-9-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10185

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
V. A. H. Fort Howard, Maryland
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4615 Asbury Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war WW

3. (a) FULL NAME

WILLIAM EISENRAUCH

3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Mrs. Mary Eisenrauch
6. (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) 10-15-90
8. AGE: Years 58 Months 0 Days 7 it less than one day
hrs. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual occupation Auto Mechanic
11. Industry or business
12. Name Anton Eisenrauch
13. Birthplace Austria
14. Maiden name Marie Schoenbargen
15. Birthplace Austria

16. Informant Clinical Records, Vet. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial 10/26/48
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Oaklawn Cemetery
Location Baltimore, Maryland

18. Funeral director Leonard J. Ruck Funeral Home
Address 5305 Harford Rd., Baltimore, Md.

19. Oct 25 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 19 48 at 11:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13 19 48 to October 22 19 48 and that I last saw him him alive on October 22 19 48

Immediate cause of death CARCINOMA OF ADRENALS DURATION 13 mos.
WITH METASTASIS TO SPINE AND PELVIS

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results Substantiated Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE John Doenges M. D. or other
Address VAH Fort Howard, Md. Date signed 10-22-48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10186

Reg. Diat. No.

43

1. PLACE OF DEATH:

County Baltimore
City or town Overlea, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Overlea, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 14 Chesley Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ETHEL I. ENSOR

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 9th, 1890 6.(c) If alive, give age

8. AGE: Years 58 Months 9 Days 21 If less than one day

9. Birthplace Baltimore County, Md.
(Town, county, and state)

10. Usual occupation Clerk
11. Industry or business U.S. Government Employee

12. Name Abraham W. Ensor
13. Birthplace Baltimore County, Md.

14. Maiden name Sarah A. Ensor
15. Birthplace Baltimore County, Md.

16. Informant Mrs. Frances Roberta Clayton
Address 14 Chesley Ave.

17. burial Date thereof 11/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bosley Methodist
Location Baltimore County -
Lassahn Funeral Home

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd.

19. Nov. 1 19 48 Ima G.L. Reipnider
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30th 19 48 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 19 48 to Oct 30 19 48 and that I last saw him alive on Oct 30th 19 48

Immediate cause of death

Cancer of stomach 3 mos

Due to

myocardial

Due to

Other conditions myocardial

(Include pregnancy within 3 months of death)

Major findings of operations Carcinomatous

Date of op. 8/26/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Edgar H. Benson

Address 1000 ... Date signed 10/31/48

MARGIN RESERVED FOR BINDING

VS. A15 9.45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1948
BUREAU V. S.

MARGIN RESERVED FOR BINDING

(I)

(W)

(3)

READING THE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10187

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Maryland

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 197 Clay St.
(If rural, give LOCATION)

2. (a) If veteran, name war WW-1

3. (a) FULL NAME

FRANK EVANS

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Annie Evans

6. (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 4, 1890

8. AGE: Years 58 Months 3 Days 26 If less than one day hrs. min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business None

FATHER 12. Name Louis Evans

13. Birthplace Anne Arundel Co. Md.

MOTHER 14. Maiden name Sophie Johnston

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial 11 - 3-1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill Cemetery

Location Annapolis, Md.

18. Funeral director Mrs. Charles Hicks, Jr.

Address 45 Northwest St. Annapolis, Md.

19. 11/1 x 8 AD. Halush
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1948, at 7:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 1948 to Oct. 30 1948

and that I last saw him alive on October 30 1948

Immediate cause of death Pulmonary Embolism DURATION sudden

Due to thrombosed iliac veins

Due to

Other conditions Post operation prostatectomy 1 day

(Include pregnancy within 8 months of death)

Major findings of operations Prostatectomy

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. F. Scullio M. D. or other

Address VAH FT. Howard, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10188

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since May 3, 1944
Hospital, institution, or street address where death occurred:
Spring Grove Hospital
How long in hospital or institution? since May 3, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4619 Frankford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Sallie FALLON

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

October 5, 1870 ?

8. AGE:

Years 78

Months ?

Days ?

It less than one day

hrs. min.

9. Birthplace

Frederick Md.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER FATHER

12. Name

John Fallon

13. Birthplace

Frederick Md.

14. Maiden name

Mary Schill

15. Birthplace

Frederick Md.

16. Informant

Hospital record

Address

Spring Grove State Hospital, Catonsville

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-20-48
(month) (day) (year)

Cemetery or crematory

New Cathedral
Baltimore, Md.

Location

Leonard J. Ruck

18. Funeral director

Address

5305 Harford Road #14

19.

(Date rec'd by registrar)

19.

48

R. W. Hedrick
Registrar

23. SIGNATURE

Address

1010 Leach Ave

Date signed Oct 17, 48

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1948 19. at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

DURATION

Acute Cardiac Failure
Due to Coronary vascular disease
Due to Senility
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Geo S. McKee
M. D. brother

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10189

Reg. Dist. No. 30

1. PLACE OF DEATH:
County **Baltimore**
City or town **Catonsville 28, Maryland**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **16 yrs. 5 mos. 28 das.**
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? **16 yrs. 5 mos. 28 das.**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State **Maryland** County
City or town **Baltimore, Maryland**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **1208 Light Street**
1210 (If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME **THEODORE FANGMAN**
3. (b) Social Security Number

4. Sex **male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **single**
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) **9/20/1889** 6. (c) If alive, give age years
8. AGE: Years **59** Months **0** Days **16** If less than one day hrs. min.

9. Birthplace **Maryland**
(Town, county, and state)
10. Usual occupation **Shipping clerk, Standard Oil Co.**
11. Industry or business **Manufacturing**
12. Name **Anthony Fangman**
13. Birthplace **Germany**
14. Maiden name **Bertha Thoben**
15. Birthplace **Germany**
16. Informant **Hospital Records**
Address **Catonsville 28, Maryland**

17. **BURIAL** Date thereof **OCT. 9-1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory **HOLY CROSS CEMETERY**
RITENIE HIGHWAY
Location
18. Funeral director **Bernard G. Hailer**
Address **121 E WEST ST.**
10/7 **48** **AW Helmer**
(Date recd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 6, 1948 2:00 a.m.**
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 8, 1932** to **October 6, 1948**
and that I last saw him alive on **October 6, 1948**

Immediate cause of death **Cholelithiasis and cholangitis** DURATION **3 weeks**

Due to
Due to
Other conditions **Jaundice** **3 weeks**

(Include pregnancy within 3 months of death)

Major findings of operations **Choledocholithotomy and choledochoduodenostomy** Date of op. **9-28-48**

Autopsy results **none**
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE **Isadore Tuerk, M.D.** M.D. or other
Address **Catonsville 28, Md.** Date signed **10/6/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10190

Reg. Dist. No. 35

1. PLACE OF DEATH:

County Baltimore
 City or town White Hall Ind
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County BALTIMORE
 City or town WHITE HALL
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

NIKOLAUS FEIBEL

3. (b) Social Security Number

NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife MABEL OCHSE
 6. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) FEB. 7 - 1883
 8. AGE: Years 65 Months 8 Days 21 If less than one day _____ hrs. _____ min.
 9. Birthplace AUSTRIA HUNGARY
 (Town, county, and state)
 10. Usual occupation FARMER

11. Industry or business

12. Name UNKNOWN
 13. Birthplace -
 14. Maiden name MARGARET -
 15. Birthplace UNKNOWN

16. Informant Mrs. Mabel Feibel
 Address White Hall Ind

17. Burial Date thereof Nov. 1 - 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore Ind

18. Funeral director Howard S. Markline

Address White Hall Ind

19. Oct. 31 19 48 Mrs. Howard S. Markline
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 19 48 at 7:12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Crushed Chest DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10/28/48

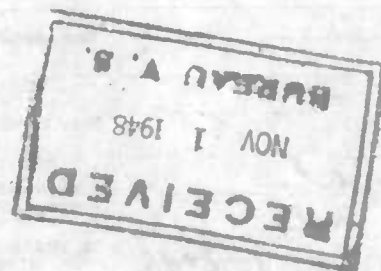
Where did injury occur? White Hall, Balto, Ind.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Automobile accident Injured at work? No

23. SIGNATURE A. M. France M. D. or other _____

Address Parkton Ind Date signed 10/29/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10191

Reg. Dist. No. *1700*

1. PLACE OF DEATH
 County *Baltimore*
 City or town *Cross - Sparrow Pt. - 19 - Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Md.* County *Balto*
 City or town *Edgemere*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *2521 Sparrow Ave*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *LAWRENCE HOLMAN FLEMING* 3. (b) Social Security Number

4. Sex *M* 5. Color or race *Col.* 6. (a) Single, married, widowed, or divorced *Single*
 6. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) *April 26, 1923*
 8. AGE: Years *25* Months Days If less than one day
 hrs. min.

8. Birthplace *MD*
 (Town, county, and state)
 10. Usual occupation *Laborem*
 11. Industry or business *Baltimore Steel Co.*
 12. Name *Lawrie Fleming*
 13. Birthplace *MD*
 14. Maiden name *Amy Britt*
 15. Birthplace *MD*

16. Informant *Amy Fleming*
 Address *376 N. Hoffman St.*
 17. *Removal* Date thereof *Oct. 9/48*
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory
 Location *Richmond Md.*
 18. Funeral director *Max Post & Sons & Daughters*
 Address *1129 N. Caroline St.*
 19. *10/9* *48* *A.W. Hedrick*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH *October 8* 19*48* at *7:00* P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 and that I last saw him alive on
 Immediate cause of death
 1. FRACTURED SKULL
 2. FRACTURED FEMUR BILATERAL
 Due to 3. FRACTURED RH HUMERUS
 Due to *Auto Accident*
 Other condition
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following: *10/8/48*
 Accident, suicide, or homicide *Accident* Date of
 Where did injury occur? *NR. SPARROWS PT. BALTO MD.* (City or town) (State)
 Injured at home, farm, industry, public place (where?) *Public Highway*
 Cause of injury *Auto ran into culvert* Injured at work? *No*
 23. SIGNATURE *M.B. Davis MD*
 DEPT. MED. EXAM - BALTO CO. M. D. *10/8/48*
 Address *DUNDALK MD* Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

10192

1. PLACE OF DEATH:

County BALTIMORECity or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

226 ST. HELENA AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTOCity or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)Street No. 226 ST. HELENA AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CONRAD GAIL

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife DORA WIEGMAN

7. Birth date of

deceased (mo., day, yr.)

MARCH 27, 1886

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

6274

hrs.

min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)10. Usual occupation FIREMAN11. Industry or business CAMP HOLIBIRD12. Name EDWARD GAIL13. Birthplace BALTO. MD14. Maiden name CATHERINE RITZ15. Birthplace BALTO. MD16. Informant DORA WIEGMAN GAILAddress 226 ST. HELENA AVE.17. RURAL
(Burial, cremation, or removal. Which?)Date thereof NOV 3, 1948
(month) (day) (year)Cemetery or crematory OAK LAWN CEMETERYLocation 7225 EASTERN AVE18. Funeral director Roland L FisherAddress 2112 DUNDALK AVE.19. 11/3
(Date registered by registrar)19. 48AW Redner
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 31

19.

48

at

8:40

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1948 to Oct 31 1948
and that I last saw him alive on Oct. 27 1948

Immediate cause of death

1. Syphilis
2. AORTIC ANEURYSM -
3. PEPTIC ULCER
4. Syphilitic Myocarditis
5. CENTRAL NERVOUS SYSTEM
- SYPHILIS

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. J. Davis M.D.
Address DUNDALK MD Date signed 11/3/48

M. D. or other

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10193

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore CountyCity or town Cotonsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 39 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Cotonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. Bloomington Ave. & Bishop Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William A. Gardner - William A. GARDNER

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Clara V. Gardner7. Birth date of deceased (mo., day, yr.) 9/30/18666. (c) If alive, give age 65 years8. AGE: Years 82 Months - Days 12 If less than one day
hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William Gardner13. Birthplace Maryland14. Maiden name Rebecca Ehardt15. Birthplace Maryland16. Informant Mrs. Clara V. GardnerAddress Bloomington Ave. & Bishop Lane17. Burial Date thereof Oct. 5, 1948
(Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Woodlawn ParkLocation Baltimore, Md.18. Funeral director F. B. McPherson & SonAddress 30. Entwaw Place19. 10/15 1948 a. 20. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948, at 99 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from months 2 1944, to Oct. 12, 1948and that I last saw him alive on October 11 1948Immediate cause of death Myocardial Decompensation

DURATION

1 mo.Due to Chs. Cardiac Decompensation -1030Renal Disease

Due to

Other conditions

(Include pregnancy within 5 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. H. K. [Signature] M. D. or otherAddress Cotonsville, Md. Date signed 10/14/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

10194

1. PLACE OF DEATH: Co.
 (a) Baltimore City, Maryland
 (b) Street address: 718 Walker Avenue
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days):
 (e) Length of stay in Baltimore (yrs., mos., or days): 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Md. (b) County: Balti.
 (c) City or town: Balto.,
 (If outside city or town limits, write RURAL and give town)
 (d) Street No: 718 Walker Avenue
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country:

3 (a) FULL NAME JAMES L. GARNES

3 (b) If veteran, name war 3 (c) Social Security Account
 No. 217-09-2368

4. Sex Male 5. Color or race Colored 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Nettie
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1893

8. AGE: Years 54 Months 10 Days 6 If less than one day
 hr. min.

9. Birthplace Suffolk County, Va.
 (Town, county, and state)

10. Usual Occupation Silk Spotter

11. Industry or business Atlantic Cleaners

12. Name John Garnes

13. Birthplace N. C.

14. Maiden Name Louise Sills

15. Birthplace Va.

16 (a) Informant Nettie Garnes

(b) Address 1216 Myrtle Avenue

17 (a) B. (b) Date thereof 10-28-48
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Star
 Location Catonsville, Md.

18 (a) Funeral director Samuel W. Sullivan

(b) Address 1011 N. Arlington Ave

Oct 27 1948 (Date received by Registrar) (b) Trustington Williams, M.D.
 Registrar

MEDICAL CERTIFICATION

20

20. DATE OF DEATH October 25, 1948, at 3 P. M.

21. I certify that I took charge of the remains described above, held an
Autopsy thereon and from the evidence obtained
 Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came
his

to death on the day stated above, and death in my
 opinion resulted from: natural causes ☐, accident ☐, suicide ☐,
 homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Subdural Hemorrhage,
left.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of
 death, fill in the following:

(a) Date of injury 10-28-48 at 3 P. M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public
 place? While at work?

(d) Means of injury

23. Signature Carl Rye M.D.

Date signed 10-26-48 Medical Examiner.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10195

Reg. Dist. No. 47

1. PLACE OF DEATH:

County Balts.
 City or town Martin Highway in Congress Rd.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balts.
 City or town Victory Villa
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Bank Court
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Jacob Getty

3. (b) Social Security Number

187-05-7203

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Margaret Anna nee
slavine

7. Birth date of deceased (mo., day, yr.)

April 12 - 1918

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3067

hrs.

min.

9. Birthplace

Centralia, Penna.
(Town, county, and state)

10. Usual occupation

11. Industry or business

Glenn Martin Co.

FATHER

12. Name

Charles Getty

13. Birthplace

Ta.

MOTHER

14. Maiden name

Sadie Yost

15. Birthplace

Pa.

16. Informant

Mrs Margaret Getty

Address

2 Bank Ct. Victory Villa

17.

(Burial, cremation, or removal) Which?

Date thereof

Oct 21/48

Cemetery or crematory

Mourland Mem PA

Location

Baltimore

18. Funeral director

Philip Herwig Sons

Address

2024 Orleans St

19.

Oct. 21 - 1948
(Date rec'd by registrar)John S. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

10/18/48

19

at

6:15

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Hypertensive C-V Disease

Due to

Coronary Occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

Wm. M. Hamm
Dundalk, Md.
 Date signed 10/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: *Baltimore*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
1269 Poplar Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*MD*..... County.....*Baltimore*
 City or town.....*Arbutus*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *1269 Poplar Ave*
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Mary Magdeline Gough

3. (b) Social Security Number
B-218-094414

4. Sex.....*F*..... 5. Color or race.....*W*..... 6. (a) Single, married, widowed, or divorced.....*M*.....

6. (b) Name of husband or wife.....*Samuel A.*

7. Birth date of deceased (mo., day, yr.) *Nov 2-1867*
 B. (c) If alive, give age..... years

8. AGE: Years.....*80*..... Months.....*11*..... Days.....*21*..... hrs. min.

9. Birthplace.....*Balto*
 (Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business.....

12. Name.....*Phillip Kuhn*

13. Birthplace.....*Germany*

14. Maiden name.....*Margaret Dussel*

15. Birthplace.....*Germany*

16. Informant.....*Samuel A Gough*

Address.....*1269 Poplar Ave. Arbutus*

17. *Burial* Date thereof.....*10/26/48*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....*Parkwood Cem*

Location.....*Parkville Balto Co.*

18. Funeral director.....*Wm Cook Inc.*

Address.....*1217 St Paul St.*

19. *10-25* *1948* *A.W. Hedrick*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct 22-1948*..... at.....*3:30 P.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Oct 16*..... to.....*Oct 22*.....
 and that I last saw him/her.....*Oct 21*..... alive on.....*1948*

Immediate cause of death.....*Coronary Failure*

Due to.....*Chr. myocarditis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*George E. Shannon M.D.*
 M. D. or other

Address.....*820 Medical Bldg*..... Date signed.....*10/23/48*

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820

CERTIFICATE OF DEATH

STATE OF NEW YORK



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

16 Fustling Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2738 Hugo Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Harry F. Gray

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

April 12 - 1882

8. (c) If alive, give age

Years

8. AGE:

Years

Months

Days

If less than one day

66

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial
(Burial, cremation, or removal, which?)

Date buried

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Oct 13 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 19 48, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 20 19 48 to October 10 19 48and that I last saw him alive on October 9 19 48

Immediate cause of death

Carcinoma of the stomach

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Data signed 10/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10198

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 541 W. Hoffman St.
(If rural, give LOCATION)2.(a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

HENRY T. GREGORY

3. (b) Social Security Number

218-05-2914

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Divorced7. Birth date of deceased (mo., day, yr.) July 31, 1920
8. (c) If alive, give age years8. AGE: Years Months Days If less than one day
28 2 8 hrs. min.9. Birthplace Oxford, N.C.
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Clarence Gregory
13. Birthplace N.C.14. Maiden name Carrie Holloway
15. Birthplace N.C.16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland17. Burial Date thereof 10/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Balto. Nat'l Cemetery
Location Baltimore, Md.18. Funeral director Charles Cooper
Address 512 N. Carrollton Ave. Balto. Md.19. October 11, 1948 A. W. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 48 at 5:35 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 4 19 48 to October 9 19 48
and that I last saw him alive on October 9 19 48Immediate cause of death Myocardial Failure DURATION 4 daysDue to Hypertension Unknown

Due to

Other conditions Mural Thrombi - ventricles
Infarcts of lungs 4 days
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Substantiated above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?)
Means of injury W. W. Shacklett Injured at work?23. SIGNATURE W. W. SHACKLETT, M.D. M. D. or other
Address VAH FT. Howard, Md. Date signed 10-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10199

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 11 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County C
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7110 German Hill Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I

3. (a) FULL NAME

ADAM GULCZYNSKI (also known as Adam Krause)

3. (b) Social Security Number

273-01-5238
Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 11-22-95
 6. (c) If alive, give age _____ years
 8. AGE: Years 52 Months 11 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Shear Operator

11. Industry or business

12. Name Laurnee Gulczynski13. Birthplace Poland14. Maiden name Mary Silver15. Birthplace Poland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 10/27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Cross, Polish Nat'l CemLocation Baltimore, Maryland18. Funeral director Howard Blight Howard H. Blight, Jr.Address 6009 Harford Rd., Balto., Md.19. Oct 26 19 48 A.M.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1948 at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 14, 1948 to October 25, 1948
 and that I last saw him alive on October 25, 1948

Immediate cause of death Carcinoma of thyroid with metastases
 DURATION 6 Mos. plus

Due to _____

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. C. MANAUGH M. D. or otherAddress VAH, Ft. Howard, Md. Date signed 10-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10200

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? since January 11, 1946
 Hospital, institution, or street address where death occurred:
Spring Grove Hospital
 How long in hospital or institution? since January 11, 1946.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard County
 City or town Ellicott City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Frederick Pike
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Thomas T. GWIN Jr

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed or divorced married
 6.(b) Name of husband or wife Eleanor Thompson
 6.(c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) February 19, 1873
 8. AGE: Years 75 Months 8 Days 5 if less than one day
 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation clerical worker
 11. Industry or business

MOTHER FATHER
 12. Name Thomas T. Gwin
 13. Birthplace Virginia
 14. Maiden name Magdalene Mohler
 15. Birthplace Virginia

16. Informant Hospital records
 Address Spring Grove State Hospital

17. Burial Date thereof 10-27-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St Johns
 Location Ellicott City Md.

18. Funeral director J.C. Higginbotham
 Address Ellicott City Md.

19. 10-25 19 48 J.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1948 19 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Stronning accidental
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

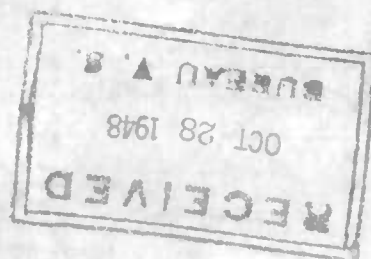
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Oct. 24, 48Where did injury occur? Catonsville Balt. Md.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HospitalMeans of injury falling bed Injured at work? no23. SIGNATURE Geo. F. Kieffer M. D. or otherAddress 1010 Leeds Ave Date signed Oct. 24, 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10201

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Garrison, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Garrison
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Rd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Annie 1 eyes Hanna

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife George W. Hanna
Deceased 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept 26, 1881
 8. AGE: Years 67 Months 7 Days 7 If less than one day hrs. min.

9. Birthplace Pikesville, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George F. Reyes

13. Birthplace Ontario, Canada

14. Maiden name Ann Mc Cabe

15. Birthplace Canada

16. Informant Laura K. Hocking

Address 5505 Narcissus av. Balto.

17. Burial Burial Date thereof Oct 5, 1948
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Stons Chapel

Location Pikesville, Maryland

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. Oct - 4 - 48 19 48 Dr. E. E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3, 1948 at 3¹⁵ P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 4, 1947 to Oct 3, 1948
 and that I last saw him alive on October 3, 1948

Immediate cause of death Arterial hemorrhage DURATION 5 hrs.

Due to arterial hypertension ?

Due to arteriosclerosis ?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Antemortem results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Nichols M.D.

Address Pikesville, Md. Date signed 10-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10202

Reg. Dist. No. 40

1. PLACE OF DEATH:

County BaltimoreCity or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

E. Joppa Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)Street No. E. Joppa Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

FANNIE J. HARRIS

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife George W. Harris

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) July 2nd, 18608. AGE: Years 88 Months 3 Days 13 If less than one day
hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Cornelius Cunningham13. Birthplace Unknown14. Maiden name --- Wood15. Birthplace Unknown16. Informant Mr. Houston N. HarrisAddress E. Joppa Rd., Fullerton, Md.17. burial Date thereof Oct. 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Balto., Md.18. Funeral director Louise Funeral HomeAddress 7401 Belair Road19. 10-17-48 19. W. M. Bennett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15th, 19 48, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.45 to Oct. 15 19 48and that I last saw him alive on Oct. 14 19 48

Immediate cause of death

ApoplexyDue to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Bacon, M.D.

M. D. or other

Address 3810 Taylor Ave. Date signed 10/14/48

RECEIVED

OCT 22 1948

BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

10204

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

VAH Fort Howard, MarylandHow long in hospital or institution? 2 days

3. (a) FULL NAME

LEROY HENDERSON

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married (Sep.)6. (b) Name of husband or wife Cora Henderson

7. Birth date of deceased (mo., day, yr.)

July 4, 18978. (c) If alive, give age ? years

8. AGE:

Years

51

Months

3

Days

3

If less than one day

hrs.

min.

9. Birthplace Wilmington, S. C.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER

12. Name

Samuel Henderson

13. Birthplace

N. Carolina

MOTHER

14. Maiden name

Sarah ?

15. Birthplace

N. Carolina16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Maryland17. Burial
(Burial, cremation, or removal. Which?)

Date thereof

Oct 11, 1948
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Charles R. LawAddress 802 Madison Ave. Balto. Md.19. 10/9
(Date used by registrar)

19

SW. Hedrick
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1043 N. Mount St.
(If rural, give LOCATION)2. (a) If veteran, name war WW

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 19 48, at 11:05 A M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 5, 19 48, to October 7, 19 48, and that I last saw him alive on October 7, 19 48

Immediate cause of death

Myocardial Insufficiency

DURATION

9 days

Due to

Due to

Other conditions Arteriosclerotic Heart Dis. with aortic and mitral insuff. 3 1/2 yrs.
Auricular Fibrillations 3 yrs.
Cardiac decompensation of IV 3 yrs.

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H.C. Manauagh
H.C. MANAUGH, M.D., CHIEF, PROFESSIONAL SERV.
Address VAH, Ft. Howard, Md. Date signed 10/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. R. H. Siver
3203 Abell Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10205 32

1. PLACE OF DEATH: **Baltimore**
County.....
City or town..... **Pikesville**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Md.** County.....
City or town..... **Baltimore**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **239 West Lafayette Ave.**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Isabella Graham Hiss

3. (b) Social Security Number

4. Sex **Female** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **July 12, 1863**

8. AGE: Years **85** Months **2** Days **18** If less than one day..... hrs. min.

9. Birthplace..... **Baltimore Maryland**
(Town, county, and state)

10. Usual occupation..... **At Home**

11. Industry or business.....

12. Name **Stevenson Hiss**

13. Birthplace **Baltimore, Md.**

14. Maiden name..... **Isabella G. Corner**

15. Birthplace **Baltimore, Md.**

16. Informant..... **Frank Corner**

Address **4308 Wentworth Road**

17. **Burial** Date thereof **Oct 4, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... **Greenmount**

Location **Baltimore**

18. Funeral director..... **Elesworth Armacost**

Address **3911 Liberty Heights Ave.**

19. **10/4** 19. **48** **DW Hedrick**
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **Oct. 1, 1948** at **3:45 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 1948** to **Oct. 1, 1948** and that I last saw her alive on **Oct. 1, 1948**

Immediate cause of death.....

Carcinomatosis

Due to..... **Carcinoma of colon** **6 mos.**

Due to..... **Generalized arteriosclerosis**

Other conditions..... **Arteriosclerotic Heart Disease**

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **Robert H. Siver M.D.**

Address..... **Calvert & 30th St.** Date signed **10-3-48**

(Siver)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10206

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Ba lto.City or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

1216 64th St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Ba lto.City or town Rosedale
(If outside city or town limits, write RURAL and give nearest town)Street No. 1216 64th St Ba lto. Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lawrence W. Johnson

3. (b) Social Security Number

213-09-2568

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Dorothea Johnson

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Aug. 25th 1905

8. AGE:

Years

Months

Days

If less than one day

43128

hrs.

min.

9. Birthplace

Ba lto. Md.

(Town, county, and state)

10. Usual occupation Garbage Collector11. Industry or business Contractor12. Name Howard Johnson

13. Birthplace

Md.14. Maiden name Lucy Porter

15. Birthplace

Md.16. Informant Mrs. L. W. JohnsonAddress 1216 64th St. Ba lto. Md17. Burial Date thereof 10 27 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Zion LutheranLocation Ba lto. Co. Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Rd19. Oct. 25 - 48
(Date rec'd by registrar)John G. Connolly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23rd 1948, at 12:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 22 1948 to Oct 23 1948and that I last saw him alive on Oct 23 1948Immediate cause of death Coronaryocclusion

DURATION

SuddenDue to Arteriosclerotic Cardio
vascular disease1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

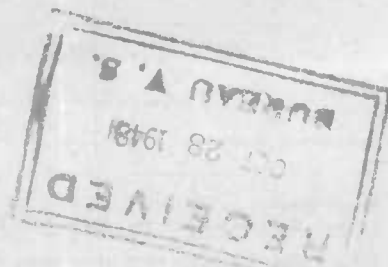
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Ba lto. 5 Date signed 10-24-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

10207

1. PLACE OF DEATH:

County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Cockeysmill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William A. Keeney

3.(b) Social Security Number

219-03-4569

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Pauline S. Keeney

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 19158. AGE: Years 33 Months 5 Days 3 If less than one day
hrs. min.9. Birthplace Carroll Co.
(Town, county, and state)10. Usual occupation Service station attendant

11. Industry or business

12. Name Alvie Keeney13. Birthplace Carroll Co.14. Maiden name Blanche Mann15. Birthplace Carroll Co.16. Informant Pauline S. KeeneyAddress Reisterstown, Md.17. Burial Date thereof Oct. 22, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FinksburgLocation Carroll Co.18. Funeral director J. F. Eline, SonsAddress Reisterstown, Md.19. 10-22- 19 48 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 19 48 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1-1- 19 30 to 10-19- 19 48and that I last saw him alive on 10-19- 19 48Immediate cause of death Cerebral oedema(acute) DURATION 6 hrsDue to alcoholism -accompanied by spasticconvulsions & vomiting.

Due to

Other conditions epilepsy.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Y. SafellAddress Reisterstown, Md. Date signed 10-20-48

M. D. or other

Address Reisterstown, Md. Date signed 10-20-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10208

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 88 days
 Hospital, institution, or street address where death occurred:
Vet. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 88 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route # 3
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW II

3. (a) FULL NAME

BERNIE J. KELLEY

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 6-15-12
 8. AGE: Year 36 Month 4 Day 11 If less than one day _____ hrs. _____ min.

9. Birthplace Princess Anne, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business _____

FATHER 12. Name Charles Kelley
 13. Birthplace Westover, Maryland
 MOTHER 14. Maiden name Amanda Bredell
 15. Birthplace Princess Anne, Maryland

16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Maryland

17. Removal Date thereof 10/27/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Salisbury Maryland
 Location George L. Church

18. Funeral director George L. Church
 Address 2101 Frederick ave Balto

19. Oct 27 - 48 Lawson T. Harris
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 48 at 10:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 48 to October 26 19 48 and that I last saw him alive on October 26 19 48

Immediate cause of death
CIRRHOSIS OF THE LIVER

DURATION
Unknown

Due to _____
 Due to _____
 Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Manner of injury _____ Injured at work? _____

23. SIGNATURE A.E. PUGH M. D. or other _____
 Address VAH. Fort Howard, Md. Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10209

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
 County.....
 City or town.....Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....18 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?.....18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Howard
 City or town.....Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Road # 2
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....✓

3. (a) FULL NAME

Mary Knight

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Widowed
 6. (b) Name of husband or wife.....George Knight
 7. Birth date of deceased (mo., day, yr.).....Oct. 23, 1848 6. (c) If alive, give age..... years
 8. AGE: Years.....99 Months.....11 Days.....24 It less than one day..... hrs. min.

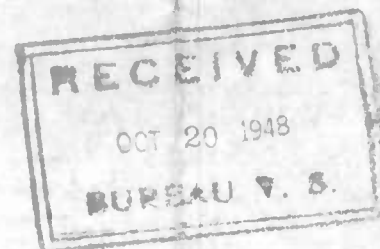
9. Birthplace.....Carroll County, Md.
 (Town, county, and state)
 10. Usual occupation.....Housewife
 11. Industry or business.....Domestic
 12. Name.....William Trost
 13. Birthplace.....Maryland
 14. Maiden name.....Ruth Barnes
 15. Birthplace.....Maryland

16. Informant.....Hospital Records
 Address.....Catonsville 28, Md.
 17. BURIAL Date thereof.....10-19-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....MT Zion
 Location.....HIGHLAND Md.
 18. Funeral director.....F.C. HIGINTHOM
 Address.....ELLICOTT CITY Md.
 19. 10-18 19 48 J.E. Harvey
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct. 17 19 48 at 7:45 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 29 19 48 to Oct. 17 19 48
 and that I last saw her alive on Oct. 17 19 48
 Immediate cause of death.....Broncho-Pneumonia, Bilateral DURATION.....3 days
 Due to.....Senility Indef.
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)
 Major findings of operations..... Date of op.....
 Autopsy results.....Not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
Sudden Death, n.o.
 23. SIGNATURE..... M. D. or other.....
 Address.....Spring Grove State Hosp. Date signed.....Oct. 17, 1948
Catonsville 28



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10210

Reg. Dist. No.

43

1. PLACE OF DEATH:

County Baltimore
 City or town Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Belair Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

ROBERT D. KNOWLES

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Oct. (abt.) 1866
 8. AGE: Years 82 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Conn.
 (Town, county, and state)
 10. Usual occupation Machinist
 11. Industry or business

FATHER
 12. Name James N. Knowles
 13. Birthplace Conn.
 MOTHER
 14. Maiden name Emilie S. Booth
 15. Birthplace Conn.

16. Informant Mrs. Emma Jane Knowles
 Address 4106 Idaho Ave.

17. burial Date thereof 10/30/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Perkins Chapel
 Location Prince George County

18. Funeral director Lassala Funeral Home
 Address 7401 Belair Rd.

19. 10/27/48 Bro. G. L. Rejzender
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th, 19 48, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 48 to Oct 27 19 48
 and that I last saw h. l. m. alive on 10-26-48 19 48

Immediate cause of death Congestive Heart Failure DURATION 2 wks.
 Due to Hypertensive Cardiovascular Disease many years.
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mal. R. English M.D. M. D. or otherAddress 5713 Belair Rd. Date signed 10-28-48

1948
82
1866



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10211

XX

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approximately 5 hours

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? Approximately 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltoCity or town Rosedale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1302 Doris Ave.,

(If rural, give LOCATION)

2. (a) If veteran, name war WW I

3. (a) FULL NAME

ANDREW KOPP

3. (b) Social Security Number

212-03-1740

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Margaret Kopp

7. Birth date of deceased (mo., day, yr.)

11-8-966. (c) If alive, give age 53 years

8. AGE:

Years

Months

Days

If less than one day

511110hrs.min.9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Shipping Department

11. Industry or business

MOTHER FATHER

12. Name

John Kopp

13. Birthplace

Unknown

14. Maiden name

Mary Newscharefen

15. Birthplace

Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Oct 21 48
(month) (day) (year)Cemetery or crematory Holy Redeemer CemeteryLocation Belair Rd., Baltimore, Md.18. Funeral director Dippel BrothersAddress Lombard and Ann Sts., Balto., Md.19. 10/20 48
(Date rec'd by registrar)

Registrar

23. SIGNATURE

Address VAH Fort Howard, Md. Date signed 10-18-48

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 48 at 6:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 18 19 48 to October 18 19 48and that I last saw him alive on October 18 19 48

Immediate cause of death

CARDIAC DECOMPENSATION

DURATION

4 yrs.Due to Cor PulmonaleUnknown

Due to

Other conditions BronchietasisUnknownStasis Dermatitis1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address VAH Fort Howard, Md. Date signed 10-18-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10212

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BALTIMORECity or town DUNPAK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

30 TOWNSHIP ROAD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTOCity or town DUNPAK
(If outside city or town limits, write RURAL and give nearest town)Street No. 30 TOWNSHIP ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES KRATZ

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife ANNIE L. SMITH

7. Birth date of

deceased (mo., day, yr.) SEPT. 9, 1864

6. (c) If alive, give age

years

8. AGE:

Years 84 Months 1 Days 1 It less than one day

hrs. min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)10. Usual occupation CARPENTER - RETIRED11. Industry or business CANTON CO.12. Name HENRY KRATZ13. Birthplace GERMANY14. Maiden name MARY HATHOUSE15. Birthplace Germany16. Informant ANNIE L. KRATZAddress 30 TOWNSHIP ROAD17. BURIAL Date thereof OCT 12, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory OLIVE LAWN CEM.Location 2225 EASTERN AVE.
BALTO. CO. MD18. Funeral director Robert L. FisherAddress 2113 DUNDALK AVE.19. Oct 11 1948 William M. Kelly, Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 10 1948, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

OCT. 1944, to OCT 5 1948and that I last saw him alive on OCT 5 1948Immediate cause of death myocarditis acutaDue to arteriosclerosisDue to chronic myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

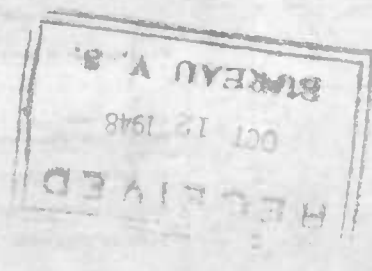
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David H. Andrews M.D.Address 2 Township Rd Dundalk Md. Date signed 10/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10213

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH

County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ada Lewis

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Texas
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Arthur Lewis

7. Birth date of deceased (mo., day, yr.)

Nov 5th, 18886. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

591119

hrs.

min.

9. Birthplace

Cockeysville Balto Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Henry Wilson

13. Birthplace

Texas, Md.

14. Maiden name

Nancy Perrine

15. Birthplace

Balto Co. Md.

16. Informant

Zola Brown

Address

Texas, Md.

17.

Burial

Date thereof

10-27-48
(month) (day) (year)

Cemetery or crematory

Basil A.M.E.

Location

Cockeysville, Md.

18. Funeral director

J. Scott Brooks

Address

Sparks, Md.

19.

10/26/48
(Date rec'd by registrar)Wilmer C. Enson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 19 48 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dr. George MacDermott - past year 19 48and that I last saw him alive on 19 48Immediate cause of death Generalized anoxia

DURATION

Due to cardiac decompensation 1 yr.Due to Hypertensive heart disease 8 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Elijah B. Schmitt, M.D.
M. D. or otherAddress Cockeysville, Md. Date signed 10-24-48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39

10214

1. PLACE OF DEATH:

County BaltimoreCity or town Monkton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Monkton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Chapel Light

3. (b) Social Security Number

4. Sex

M

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

unknown Oct. 1880

8. AGE:

68

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Farmer hand

11. Industry or business

FATHER

12. Name

13. Birthplace

unknown

MOTHER

14. Maiden name

15. Birthplace

unknown

16. Informant

Address

Miss Bessie Hutchins
Sparks, Monkton, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof

10-15-48
(month) (day) (year)

Cemetery or crematory

Gessoss Methodist

Location

Sparks, Md.

18. Funeral director

Address

Scott Brooks
Sparks, Md.

19.

(Date rec'd by registrar)

19

48Anna Price

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 15 1948 at 9 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

pleuro pneumonia

Due to

myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. France

M. D. or other

Address

Parthory, Md.

Date signed

10/15/48

2881
1986
8761

RECEIVED

OCT 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on Film
G118 11/16/48 js

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH 93d

10215

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State.....md. County.....Baltimore
City or town.....Oella, md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Lydia H. Lincoln.

3. (b) Social Security Number

4. Sex.....Female
5. Color or race.....C
6.(a) Single, married, widowed, or divorced.....
6.(b) Name of husband or wife.....Carroll Lincoln
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.).....June 22, 1914. 1904

8. AGE: Years.....34 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Oella Md..
(Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....

12. Name.....Cabel Hall

13. Birthplace.....Oella, Md.

14. Maiden name.....Nellie Lawson

15. Birthplace.....Oella Md.

16. Informant.....Nellie Hall
Address.....Oella, Md.

17. Burial
(Burial, cremation, or removal, Which?) Date thereof.....October 31, 1948
(month) (day) (year)
Cemetery or crematory.....Oella
Location.....Oella Md.

18. Funeral director.....Mrs Katie P. Williams
Address.....322 N Schroeder St.

19. Oct 30
(Date rec'd by registrar).....SW. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct 27 19.....48 at.....1015 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....10-1-48 19..... to.....10-27-48 19.....
and that I last saw him alive on.....10-27-48 19.....

Immediate cause of death.....Acute Myocarditis
Due to.....Supertensive
cardiac disease
Due to.....
Other conditions.....

DURATION

3 day?

(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?.....
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE.....E. J. Maloney MD
M. D. or other
Address.....Calverville Md. Date signed.....10/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10216

43

1. PLACE OF DEATH

County Balto.City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Ridge Rd. 1/2 mile E. Belair Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Fallston #6
(If outside city or town limits, write RURAL and give nearest town)Street No. Bv 481A Ridge Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Dennis Charles Little

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 9/1943

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

559

hrs.

min.

9. Birthplace

Ridge Rd. Box 481 Rosedale Balto. Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Char. H. Little

13. Birthplace

Balto. City Md.

MOTHER

14. Maiden name

Little Mrs.

15. Birthplace

Balto. Co. Md.

16. Informant

Mr. C. H. Little

Address

Ridge Rd. Box 481A Rosedale Balto. Co. Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Oct. 29, 1948
(month) (day) (year)

Cemetery or crematory

Parkwood Cemetery

Location

Taylor Ave.

18. Funeral director

Seashore Funeral Home

Address

7401 Belair Rd. Balto. Co. Md.

19. Cor.

27

19

1948

Mrs. G. L. Reipmiller

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 26, 1948 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

fracture base skullfracture lower jawfracture mid lower leg

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

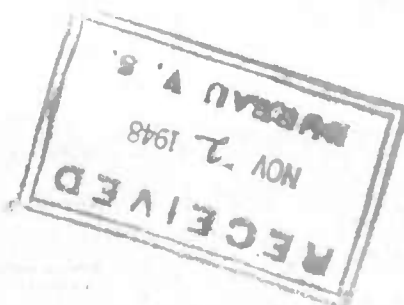
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/26/48Where did injury occur? Fallston Balto. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Belair RdMeans of injury Automobile Injured at work? no

23. SIGNATURE

M. Barmine M.D.Deputy Medical ExaminerAddress Balto. Co. Rosedale Date signed 10/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

10217

1. PLACE OF DEATH
 County..... Baltimore - 22
 City or town..... Dundalk
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:
Box 83 LYNCH ROAD
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... County.....
 City or town..... As in # 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... NONE

3. (a) FULL NAME
PAUL MACEK

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... WIDOWED
 6. (b) Name of husband or wife..... MARY MACEK
 7. Birth date of deceased (mo., day, yr.)..... JUNE 29, 1981 6. (c) If alive, give age..... years

8. AGE: Years..... 67 Months..... 3 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... CZECHOSLOVAKIA
 (Town, county, and state)

10. Usual occupation..... LABORER

11. Industry or business..... GENERAL

12. Name..... ADAM MACEK

13. Birthplace..... CZECHOSLOVAKIA

14. Maiden name..... EVE

15. Birthplace..... CZECHOSLOVAKIA

16. Informant..... JOHN LOUIS MACEK

Address..... AS IN # 1

17. Burial Date thereof..... 10/28/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Sacred Heart

Location..... German Hill Road

18. Funeral director..... Jelly & Zailer Inc

Address..... 403 S. Wolfe Street

19. 10-27-48 Dr. Hedding
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... OCTOBER 25, 1948 at..... 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 2, 1948 to Oct. 25, 1948
 and that I last saw him alive on Oct. 25, 1948

Immediate cause of death.....

DURATION

Coronary Thrombosis 1 day

Due to..... Arteriosclerotic

Due to..... Coronary disease - 6 yrs

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Louis N. Gallin M. D.

23. SIGNATURE..... M. D. or other

Spamman P. Red Date signed 10/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

10218

1. PLACE OF DEATH:

County..... Parkville
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2711 Glendale Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Parkville

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2711 Glendale Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MARIE E. MAIENSHEIN

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife..... John F. Maienshein

7. Birth date of deceased (mo., day, yr.) June 28, 1914
6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
34 3 29 hrs. min.

9. Birthplace..... Philadelphia
(Town, county, and state)
at home

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... Edward C. Hettel
13. Birthplace..... Phila.

MOTHER 14. Maiden name..... Emma Schmieder
15. Birthplace..... Phila.

16. Informant..... Mr. John F. Maienshein
Address..... 2711 Glendale Road

17. Burial Date thereof..... 10-30-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Moreland Park
Location..... Baltimore, Md.

18. Funeral director..... Leonard J. Ruck
Address..... 5305 Harford Road #14

19. Oct 27 19 48 A. W. Haddick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 27th 19 48, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 48 to Oct 27 19 48
and that I last saw him alive on 10/27 19 48

Immediate cause of death.....

DURATION

Carcinoma of the
brain 1 yr.

Due to.....
Due to.....
Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Harold A. Grott, M.D.
M. D. or other
Address..... 8100 Harford Rd. Date signed..... 12/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10219

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
6210 Frederick Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 6210 Frederick Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Howard G. Maloney

3. (b) Social Security Number

4. Sex Male 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Late Ida J. Maloney
(nee Vierengel) 6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) March 21, 1884.8. AGE: Years 64 Months 7 Days If less than one day
.....hrs.min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Baltimore Transit Co.12. Name Daniel Maloney
13. Birthplace Md.14. Maiden name Elizabeth Hess
15. Birthplace Md.16. Informant Howard F. Maloney
Address 6210 Frederick Road17. Burial Date thereof Oct. 25/48.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park
3801 Frederick Road
Location18. Funeral director Harry H. Witzke
Address 4101 Edmondson Ave.19. 10-23 19 48 U.E. Harry Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 19 48 at 330 M21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Feb 19 48, to 10/21 19 48
and that I last saw him live on 10/21 19 48Immediate cause of death Carcinomatosis DURATION

Due to

Due to

Other condition Human carcinoma & MI
gluc
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Daniel P. Paggi M.D. or otherAddress 3316 Frederick St. Date signed 10/24/48

RECEIVED

OCT 25 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10220

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 219 Newburg Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Linda L Marquess

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

August 23 1948

8. AGE:

Years

Months

Days

If less than one day

23

hrs.

min.

9. Birthplace

St Agnes Hosp Balt Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Alfred Marquess

13. Birthplace

Md

MOTHER

14. Maiden name

Evelyn I. Sterner

15. Birthplace

Md

16. Informant

Alfred MarquessAddress 219 Newburg Ave. Catonsville, Md

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof

10-27-48

(month) (day) (year)

Cemetery or crematory Good Shepherd

Location

Ellicott City Md

18. Funeral director

F. C. Higinbotham

Address

Ellicott City Md.

19.

10-27

19

48

(Date rec'd by registrar)

VE Harry

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 48 at 8:10 a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Asphyxiation Accidental

Due to

Regurgitation of food

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Oct 26 48Where did injury occur Catonsville Baltimore
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Regurgitation of food Injured at work?

23. SIGNATURE

M. D. or other

Address 1010 Reddon Date signed Oct 26 48

MARGIN RESERVED FOR BINDING

VS A15

9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 29 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10221

Reg. Dist. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. York Rd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Martha Ann Matthews

3. (b) Social Security Number

4. Sex Female5. Color or race Caucasian6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife George St.7. Birth date of deceased (mo., day, yr.) Feb. 8, 1871

6. (c) If alive, give age _____ years

8. AGE: Years 77 Months 8 Days 22 hrs. _____ min.9. Birthplace Harford Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Lila A. YoungAddress York Rd. Towson, Md.17. Burial Date thereof Nov. 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Evergreen Cem.Location Harford Co. Md.18. Funeral director Mrs. George J. HallAddress 1631 Union Hill Ave.19. 11/2 1948 Sh. Medick
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1948 at 5:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 48 to Oct 30 48
and that I last saw her alive on Oct 30 1948Immediate cause of death Cerebral hemorrhage

DURATION

Due to hypertension unknown

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results none Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Bennett A. Stoen M. D. or other _____Address Butterfield Date signed 10/30/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10222 37

1. PLACE OF DEATH:

County Baltimore
 City or town Rural - Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 years
 Hospital, institution, or street address where death occurred:
Bosley Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Rural - Cockeysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Bosley Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Goddard Mattingly

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Elizabeth S. Mattingly
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) October 16, 1880
 8. AGE: Years 68 Months — Days — If less than one day
— hrs. — min.

9. Birthplace St. Marys Co. Maryland
 (Town, county, and state)
 10. Usual occupation Lumber merchant
 11. Industry or business Lumber - Baltimore
 12. Name James Ignatius Mattingly
 13. Birthplace St. Marys Co. Maryland
 14. Maiden name Maria Goddard
 15. Birthplace St. Marys Co. Maryland

16. Informant Elizabeth S. Mattingly
 Address Towson, 4 R. F. D. 8, Maryland

17. BURIAL Date thereof 10 19 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory NEW CATHEDRAL
 Location BALTO., MD.

18. Funeral director HENRY W. JENKINS & SONS Co.
 Address 4905 YORK RD. BALTO., MD.

19. 10/18 19 48 A. W. H. H. H.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 October 19 48 at 11:03 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
15 July 19 48 to 16 October 19 48
 and that I last saw him alive on 16 October 19 48

Immediate cause of death Coronary thrombosis DURATION 1 day

Due to Arterio-sclerotic heart disease 2 years

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Walter T. Kees M.D. M. D. or other
 Address Cockeysville, Md. Date signed 10-16-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10223

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)Street No. Pleasant Hill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Donald E. Maxwell

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife Mary F. Maxwell

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1900

8. AGE:

48 years5 Months17 Days

If less than one day

hrs. min.

9. Birthplace

Hansen Wisconsin
(Town, county, and state)

10. Usual occupation

Mechanic at sawmill

11. Industry or business

FATHER
MOTHER

12. Name

John Maxwell

13. Birthplace

Edenburg Scotland

14. Maiden name

Annie Woodruff

15. Birthplace

Hansen Wisconsin

16. Informant

Leona Lloyd

Address

Cwings Mills, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Oct. 15, 1948
(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Balto. Co.

18. Funeral director

J. F. Elmer - Sons

Address

Reisterstown, Md.

19.

10-13- 19 48
(Date rec'd by registrar)Mary B. Elmer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 12 19 48 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 17 19 48 to Oct 12 19 48
and that I last saw him alive on Oct - 11 - 19 48

Immediate cause of death

DURATION

Pulmonary tuberculosis?

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

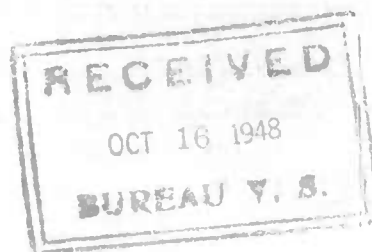
Address Pleasant Hill Rd Date signed 10-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

10224

1. PLACE OF DEATH: -

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1030 Patapsco Avenue
 (If rural, give LOCATION)
 2.(d) if veteran, name war _____

3. (a) FULL NAME

Edward W. Mayhew

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 15, 1895
 8. AGE: Years 53 Months 6 Days 14 If less than one day _____ hrs. _____ min.
 9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name John Samuel Mayhew
 13. Birthplace Maryland
 14. Maiden name Elizabeth Shenkel
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 11/11/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mt Olivet Cem.
 Location 2930 Frederick Ave
 18. Funeral director John J. Cowan & Son
 Address 901-03 Hollins St.
 19. Nov. 1 1948 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1948 at 1:20p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 29 1948 to October 29 1948
 and that I last saw him alive on October 29 1948
 Immediate cause of death _____
Carcinoma of the larynx with
extensive metastasis DURATION indefinite
 Due to _____
Pharyngo-cutaneous fistula 2 weeks
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations Tracheotomy - date unknown;
Gastrostomy performed Date of op. 10-28-48
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, pub'c place (where?) _____
 Means of injury _____ Injured at work? _____
Isadore Tuerk, M.D.
 23. SIGNATURE _____ M. D. or other _____
 Address Catonsville-28, Md. Date signed 10-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) ~~Baltimore City, Maryland~~ *Parlinton Balto. Co., Md*(b) Street address *Mt. Carmel Road*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *Lifetime*

3 (a) FULL NAME

William Henry Mays

3 (b) If veteran, name war

No

3 (c) Social Security Account

No. *None*

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

*Annie Mabel (Turner)*6 (c) If alive, give age *47* years

7. Birth date of deceased (mo., day, yr.)

Nov. 2 1889

8. AGE:

Years

Months

Days

If less than one day

*58**11**20*

hr.

min.

9. Birthplace

Balto. Co., Md.

(Town, county, and state)

10. Usual Occupation

Farmer

11. Industry or business

12. Name

J. Grant Mays

13. Birthplace

Balto. Co., Md.

14. Maiden Name

Sallie Tricey

15. Birthplace

Balto. Co., Md.

16 (a) Informant

Mrs. Wm. H. Mays

(b) Address

Parlinton, Md.

17 (a)

Burial

(b) Date thereof

Oct. 23, 1948

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Mt. Carmel

Location

Mt. Carmel, Balto. Co., Md.

18 (a) Funeral director

London on Buicks

(b) Address

Garls, Md.

19 (a)

10-26-48

(b)

Mary B. Eline

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*

(b) County

Baltimore

(c) City or town

Parlinton (Rural)

(If outside city or town limits, write RURAL and give town)

(d) Street No.

Mt. Carmel Rd

(If rural give location)

(e) Citizen of foreign country?

No

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Oct. 22*19*48*, at *9:14* M

21. I certify that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____,

and that I last saw him _____ 19____.

Immediate cause of death

*Head on arrival
Crushed chest*

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide *Accident*

(b) Date of occurrence

*10/22/48*at *9 A M*

(c) Where did injury occur?

Parlinton, Balto. Co., Md.

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? *Yes* While at work? *yes*

(Specify type of place)

(e) Means of injury

Crushed by a bull

23. Signature

J. M. France

Address

*Parlinton, Md.*Date signed *10/24/48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10226

Reg. Dist. No.

38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

413 Georgia Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 413 Georgia Court
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARRY ELMER MERRYMAN

3. (b) Social Security Number

215-16-9132

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Martha Parks Merryman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1879

8. AGE:

Years

Months

Days

It less than one day

69829— hrs.— min.9. Birthplace Ashland, Balto. Co., Maryland
(Town, county, and state)10. Usual occupation Inspector - Water Dept.11. Industry or business Balto. Co., Metropolitan Dist.12. Name George L. Merryman13. Birthplace Maryland14. Maiden name Katherine Cross15. Birthplace Maryland16. Informant Mrs. Harry E. MerrymanAddress 413 Georgia Court, Towson, Md.17. Burial Date thereof Oct. 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Prospect Hill CemeteryLocation Towson, Maryland18. Funeral director John Busch, SonsAddress Towson, Md.19. Oct. 29, 1948 W. Carroll Van Horn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 28, 1948 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30th 1948 to Oct. 28th 1948and that I last saw him alive on Oct. 28th 1948.

Immediate cause of death

DURATION

Coronary Thrombosis 1 monthDue to Severe Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel J. Hoo. Jr. M. D. or other
Towson, Md. Date signed Oct 30, 1948

RECEIVED

DEC 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10227

44

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age.....years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him

alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

NOV 1 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10228

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto. Co. Md.City or town Parkville Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

3036 Moreland Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 3036 Moreland Ave.
(If rural, give LOCATION)2. (a) If veteran, name war no

3. (a) FULL NAME

James S. Mitchell

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Katie Mitchell

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.) June 30th 1862

8. AGE:

Years 86

Months

3

Days

5

If less than one day

..... hrs. min.

9. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Mrs. James S. Mitchell

Address

3036 Moreland Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

10/7/48
(month) (day) (year)

Cemetery or crematory

Christ Ch. Bur.

Location

Harford Co. Md.

18. Funeral director

James S. Mitchell

Address

7401 Belair Rd.

19. Oct 6

(Date rec'd by registrar)

1948

A. W. Boen
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct. 5th 1948 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1947 to Oct. 5, 1948and that I last saw him alive on Oct. 5, 1948

Immediate cause of death

DURATION

Arteriosclerotic cardio-vascular disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

N. A. Grott, M.D.
M. D. or otherAddress 8100 Harford Rd. Date signed 10/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 8 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10229

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 years, 10 months, 11 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 20 years, 10 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Eastern Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

MARY MORAWSKA

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed or divorced widowed
 6. (b) Name of husband or wife unknown
 7. Birth date of deceased (mo., day, yr.) 1882?
 8. AGE: Years 65? Months ? Days ? If less than one day hrs. min.

9. Birthplace Poland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Domestic
 12. Name unknown
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown

16. Informant Hospital records
 Address Catonsville 28, Md.
 17. BURIAL Date thereof 11-1-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory ST. STANISLAUS CEM.
 Location DUNDALK AVE.
 18. Funeral director LILLY & ZELER INC.
 Address 403 S. WOLFE ST.
 19. 11/1 19 48 Isadore Tuerk
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1948 at 3:16 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 23, 1927 to October 4, 1948
 and that I last saw her alive on October 4, 1948

Immediate cause of death Acute pulmonary oedema DURATION 10 minutes

Due to Degenerative cardiovascular disease indefinite
 Due to Senility if

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)
 Means of injury Isadore Tuerk, M.D. Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other
 Address Catonsville 28, Md. Date signed 10/4/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10230

44

1. PLACE OF DEATH:

County Baltimore - 19.City or town Sparrans Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

3111 White Way Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Virginia CountyCity or town Boonesville P.O.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war none ✓

3. (a) FULL NAME

NETTIE ORA MORRIS

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Eugene Morris
deceased

7. Birth date of

deceased (mo., day, yr.)

Aug. 12. 1878

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

70215hrs.

min.

9. Birthplace

Albemarle Co. Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

own home

FATHER

12. Name

James F. Norris

13. Birthplace

Va

MOTHER

14. Maiden name

name unknown

15. Birthplace

Va

16. Informant

Lonnie Morris

Address

as in # 1

17.

(Burial, cremation, or removal. Which?)

Removal

Date thereof

10-28-48

(month) (day) (year)

Cemetery or crematory

Preddey Funeral Home

Location

Charlottesville, Va.

18. Funeral director

Lilly and Zeiler, Inc.

Address

403 S. Wolfe, St. Balto. 31, Md.

19.

(Date rec'd by registrar)

October 28 19 48A. W. H. H. H.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

October 27 19 48 at 145 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 27 19 48 to Oct 27 19 48and that I last saw him/her alive on Oct. 27 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

10 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lonnie H. Toller M.D.

M. D. or other

Address

Date signed

10/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10231

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 59 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 59 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)Street No. West End Drive
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

3. (a) FULL NAME

CHARLES E. MYERS

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bessie Myers7. Birth date of deceased (mo., day, yr.) 7-9-938. (c) If alive, give age 51 years8. AGE: Year 55 Months 3 Days 7 If less than one day
..... hr. min.9. Birthplace Baltimore County, Md.
(Town, county, and state)10. Usual occupation Grocery Clerk

11. Industry or business

12. Name Andrew P. Myers13. Birthplace Baltimore County, Md.14. Maiden name Margaret Harris15. Birthplace Baltimore County, Md.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 10/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louden Park Cemetery
Baltimore, Md.

Location

18. Funeral director Wm. J. Tickner & SonsAddress Baltimore, Maryland19. 10/18/48 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 19 48 at 10:30A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 18, 19 48 to October 16, 19 48
and that I last saw him alive on October 16, 19 48Immediate cause of death
Ulcerative bacterial endocarditis
of mitral and aortic valves

DURATION

8 Mos.Due to Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul W. RomanPAUL W. ROMAN, M.D. M. D. or otherAddress VAH, FT. HOWARD, MD. Date signed 10-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10232

Reg. Dist. No. 33

1. PLACE OF DEATH:

County..... Baltimore
City or town..... Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Died in car
Hospital, institution, or street address where death occurred:
Butler Rd Glyndon Md
How long in hospital or institution?..... -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
City or town..... Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 31 Chatsworth Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war..... No

3. (a) FULL NAME

Leonard Naylor

3. (b) Social Security Number

216-05-7091

4. Sex..... M 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... M

6. (b) Name of husband or wife..... Marjorie Buell

6. (c) If alive, give age..... 52 years

7. Birth date of deceased (mo., day, yr.)..... October 8 1892

8. AGE: Years..... 56 Months..... - Days..... 19 If less than one day..... hr. min.

9. Birthplace..... Butler Balto Co Md
(Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business..... -

12. Name..... U Grant Naylor

13. Birthplace..... Butler Md

14. Maiden name..... Lydia Combs

15. Birthplace..... Unknown

16. Informant..... Mrs Leonard Naylor

Address..... 31 Chatsworth Ave Reisterstown

17. Burial..... Burial Date thereof..... Oct 30 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Druid Ridge Cemetery

Location..... Pikesville Md

18. Funeral director..... Wm Berryman & Sons

Address..... Reisterstown Md

19. 10-29-48 Mary B. E. Line
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 27 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct 27 1948 to Oct 27 1948

and that I last saw him alive on Not seen alive 1948

Immediate cause of death..... Coronary artery Disease DURATION..... 1 yr

Due to..... Arteriosclerosis 2 yrs

Due to.....

Other conditions..... Epilepsy 1 yr

(Include pregnancy within 3 months of death)

Major findings of operation..... None Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... None Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'ic place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... D. D. Caples M.D. Exam.

Address..... Reisterstown Md M. D. or other

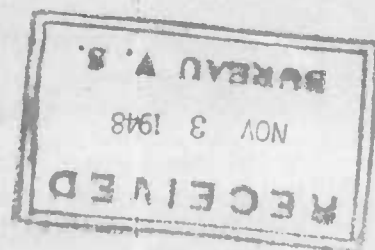
Date signed..... 10-29-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10233

Reg. Dist. No. 32

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Mount Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 0 yrs., 3 mos., 14 days
 Hospital, institution, or street address where death occurred: Mt. Wilson
Branch, Md. T. B. Sanatorium
 How long in hospital or institution? 0 yrs., 3 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2503 Washington Blvd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

William Franklin Neveker

3. (b) Social Security Number

Unknown

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Divorced
 6. (b) Name of husband or wife..... Anna Neveker
 6. (c) If alive, give age..... 42 years
 7. Birth date of deceased (mo., day, yr.)..... February 3, 1896
 8. AGE: Years..... 52 Months..... 8 Days..... 2 It less than one day..... hrs. min.

9. Birthplace..... Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation..... Pipe Fitter's Helper
 11. Industry or business.....
 12. Name..... William Neveker
 13. Birthplace..... Unknown
 14. Maiden name..... Emma Conaway
 15. Birthplace..... Kent Co., Maryland

16. Informant..... William F. Neveker, Jr.
 Address..... 2503 Washington Blvd., Balto., Md.
 17. Burial Date thereof..... Oct. 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Mt. Olivet Cemetery
 Location..... 2930 Frederick Ave., Balto., Md.
 18. Funeral director..... John F. Denny, Inc.
 Address..... 715 Light St., Balto., Md.

19. 10/5/48 19..... John R. Neveker
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 5, 1948 12:25 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 21, 1948 to Oct. 5, 1948
 and that I last saw him alive on October 5, 1948

Immediate cause of death..... Pulmonary Tuberculosis DURATION..... 2 yrs. 4 mos.

Due to..... Tubercle Bacilli
 Due to.....

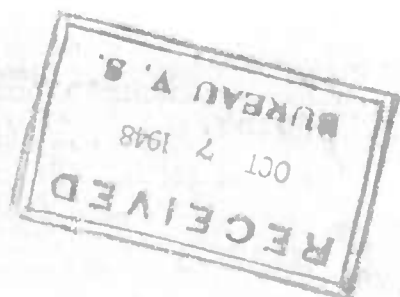
Other conditions..... Tuberculous left elbow joint. Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations..... No operation
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... Stewart S. Shaffer, M.D. M. D. or other
 Address..... Mt. Wilson, Md. Date signed..... 10/5/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10234

30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5313 Edmondson Ave (Hood Nursing Home)

How long in hospital or institution? 18 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 N. Woodington Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN NELSON NORRIS

3. (b) Social Security Number

215-18-6488 A

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife Annie Dale Norris

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1867

8. AGE: Years Months Days It less than one day
81 1 9 hrs. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation Retired Bank Clerk

11. Industry or business Federal Reserve Bank

12. Name George Norris

13. Birthplace Balto. Co., Md.

14. Maiden name Caroline Worth

15. Birthplace Balto. Co.

16. Informant Mr. G. Ellsworth Norris

Address 3508 Lunchester Rd.

17. Burial Date thereof 10/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Oct 19 19 48 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 19 48 at 3:42 a.m.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from June 19 44 to Oct 17 19 48

and that I last saw him alive on Oct 16 19 48

Immediate cause of death

Acute Cardiac Failure

Due to Arteriosclerotic Cardiovascular Disease

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. B. T. M.D.

Address 3108 E. Edman Ave Date signed 10/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10235 38

1. PLACE OF DEATH:

County BaltimoreCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Parkville
(If outside city or town limits, write RURAL and give nearest town)Street No. 7913 Ardmore Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CAROLINE E. OELMANN

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife Rudolph A.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 18898. AGE: Years Months Days If less than one day
58 9 7 hrs. min.9. Birthplace Baltimore, Md
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Lachman
13. Birthplace Germany14. Maiden name Caroline S. Lachman15. Birthplace Baltimore, Md.16. Informant Rudolph A. Oelmann
Address 7913 Ardmore Ave. Parkville17. Burial Date thereof 10/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Parkville, Md.18. Funeral director William Cook, Inc.
Address 1217 St. Paul St.19. Oct 2 19 48 A. M. Boese
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1948 19 at 2:00AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 17 19 48 to Sept. 29 19 48
and that I last saw him alive on Sept. 29 19 48Immediate cause of death 1. Rheumatic Heart Disease - years
with cardiac in-
farment, aortic & mitral
disorder and Anasarca.
Due to 2. Hypertension, Essential, years
3. Generalized Arteriosclerosis.
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert L. Williams MD
Address 3515 Taylor Ave. Balt. Md. Date signed 10-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED OCT 4 1948

RECEIVED OCT 4 1948

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RECEIVED OCT 4 1948

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10236

Reg. Dist. No. 4x

1. PLACE OF DEATH County <u>Baltimore - 19.</u> City or town <u>Spawsons Point</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 years.</u> Hospital, institution, or street address where death occurred <u>2607 E. Lodge Forrest Rd.</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Balto</u> City or town <u>PO Box #1</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>2607 E. Lodge Forrest Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>None</u>			
3. (a) FULL NAME <u>John Michael Pawlak.</u>				3. (b) Social Security Number <u>216-09-7738</u>			
4. Sex <u>male.</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>married.</u>			
8. (b) Name of husband or wife <u>Catherine Frances Pawlak.</u>				6. (c) If alive, give age <u>58</u> years			
7. Birth date of deceased (mo., day, yr.) <u>June 6 - 1887</u>							
8. AGE: Years <u>61</u>		Months <u>4</u>		Days <u>9</u>		If less than one dayhrs.min.	
9. Birthplace <u>Baltimore md.</u> (Town, county, and state)							
10. Usual occupation <u>Fireman</u>							
11. Industry or business <u>Fireboat</u>							
FATHER	12. Name <u>Joseph Pawlak</u>						
	13. Birthplace <u>Poland</u>						
MOTHER	14. Maiden name <u>Marcianna ?</u>						
	15. Birthplace <u>Poland</u>						
16. Informant <u>Catherine Pawlak</u> <u>as in #1</u>							
17. BURIAL Date thereof <u>OCT 19 1948.</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>HOLY CROSS</u> Location <u>GERMAN HILL RD.</u>							
18. Funeral director <u>THE DIPPEL BROTHERS</u> Address <u>1800 E LOMBARD ST.</u>							
19. 10/18 (Date rec'd by registrar) <u>X P. W. Hedrick</u> Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>Oct. 15.</u> 19 <u>48</u> at M							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to <u>Oct. 15</u> 19 <u>48</u> and that I last saw h. <u>1 m</u> alive on <u>Oct 15</u> 19 <u>48</u>							
Immediate cause of death <u>myocardial decompensation</u>						DURATION <u>4 days.</u>	
Due to <u>mitral stenosis.</u>						<u>6 years</u>	
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>Louis M. Tollin M.D.</u>							
Address <u>Spawsons Pt. Md.</u> No. or other <u>10/15/48</u>							
Date signed							

Evidence for correction
of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10237

FILM No. G 117 OCT 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. XX

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2567 Frederick Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war VV-I

3. (a) FULL NAME

GEORGE W. PEACOCK

3. (b) Social Security Number

218-09-7698

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife Single

7. Birth date of

deceased (mo., day, yr.)

9-29-1893

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

55

0

18

hrs.

min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Guard

11. Industry or business

MOTHER FATHER

12. Name Charles Peacock

13. Birthplace Baltimore, Maryland

14. Maiden name Amanda Gearhart

15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial

Date thereof

10-20-48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 10-19-48

19

20

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15 1948 to October 17 1948

and that I last saw him alive on October 11 1948

Immediate cause of death

ARTERIOSCLEROTIC HEART DISEASE

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

3. SIGNATURE CHARLES STRAHAN M.D.

M. D. or other

Address VAH, Fort Howard, Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10238

1. PLACE OF DEATH

County BaltimoreVillage or City Anneslie

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

Registration Dist. No. _____

No. 708 Murdock Rd. St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

2. FULL NAME

SARAH JANE PERRY(a) Residence: No. 3721 Hanover St.St. _____ Ward. Baltimore City ✓

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (<i>write the word</i>) <u>married</u>
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5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofSydney James Perry6. DATE OF BIRTH (month, day, and year) Sept. 4, 1888

7. AGE Years <u>60</u>	Months <u>0</u>	Days <u>29</u>	if LESS than 1 day, _____ hrs. or _____ min.
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OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc. Housewife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town) England
(State or country)13. NAME Josiah Swift14. BIRTHPLACE (city or town) England
(State or country)15. MAIDEN NAME Anne Pritchard16. BIRTHPLACE (city or town) England
(State or country)17. INFORMANT Mr. Sydney J. Perry
(Address) 3721 Hanover St., Balto. 25, Md.18. BURIAL, CREMATION, OR REMOVAL
Place Cedar Hill Cem. Date 10/5/48, 19__19. UNOERTAKER WM. J. TICKNER & SONS
(Address) Baltimore, Md.20. FILED 10/8, 19__ 48 AW Hedrick
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Oct 2 1948
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from
Dec 1947, to 2 Oct 1948I last saw h. en elive on 2 Oct 1948, death is saidto have occurred on the date stated above, at 10 A. m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Date of onset

Carcinoma of Ovary 1944
ovary

Other Contributory Causes of Importance:

Name of operation Report on Date of 1948
What test confirmed diagnosis Pathological studies Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19__

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Charles N. Prier(Address) 6701 York Rd. Balto. 12 Md

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

10239

1. PLACE OF DEATH:
County Balto.
City or town White Marsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred
Rt 40 - Campbell crossing
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County
City or town Balto # 5
(If outside city or town limits, write RURAL and give nearest town)
Street No. 905 N. Maderna St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Richard Jerome Petr 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) May 24 - 1928 6.(c) If alive, give age years
8. AGE: Years 20 Months Days If less than one day
hrs. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual occupation Unemployed
11. Industry or business
12. Name Joseph Petr
13. Birthplace Chesham
14. Maiden name Barbara Rachel
15. Birthplace Balto.

16. Informant Joseph Petr
Address 905 N. Maderna St.
17. Burial Date thereof Oct. 27 - 48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Holy Redeemer
Belair Road
Location

18. Funeral director Frank Cynch & Son
Address Ashland & Chester Sts.
19. Oct. 23 19 48 Dr. J. Connolly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 48 at 630 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19. to 19.
and that I last saw him alive on 19.

Immediate cause of death Fractured base skull
& lower jaw bone
Due to Internal Injury
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10/27/48
Where did injury occur? White Marsh Rd off Balto # 5
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Rd
Means of injury Auto Injured at work? no

23. SIGNATURE Dr. J. Connolly M.D. or other
Address 1501 C. Dr. Dr. Connolly Date signed 10/23/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10240

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Edgemoor
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

412 Woodbine Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Balto.City or town Edgemoor
(If outside city or town limits, write RURAL and give nearest town)Street No. 412 Woodbine Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ernest F. Phillips

3. (b) Social Security Number

213-10-4372

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

nee HolsEthel Phillips

7. Birth date of

deceased (mo., day, yr.)

Feb. 13 - 18936. (c) If alive, give age 43 years

8. AGE:

Years

55

Months

8

Days

17

If less than one day

.....hrs.min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

Balto. Chevrolet Plant

MOTHER FATHER

12. Name

George Phillips

13. Birthplace

Germany

14. Maiden name

Unknown

15. Birthplace

Germany

16. Informant

mo. Ethel Phillips

Address

412 Woodbine Ave.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

11/21/48
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave. Blvd.

18. Funeral director

John G. Bonnelly

Address

418 Eastern Ave. Essex Md.

19.

(Date rec'd by registrar)

11/1/48

19.

John G. BonnellyRegistrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1948, at 12.20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 1948 to Oct 30 1948and that I last saw him alive on 10/29 1948

Immediate cause of death

Respiratory failure

DURATION

12 hr.

Due to

Uremia

Due to

Carcinoma of bladder with metastases

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Inoperable carcinoma
bladderDate of op. 9/16/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph G. Ricelli

M. D. or other

Address 422 Eastern Ave.Date signed 11/1/48

8761 7-1

NOV 1 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10241

30

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

10111 Chateaufort Home EdmonsonHow long in hospital or institution? 3 months 6 days emergency

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants, give residence of mother)

State Md County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 1242 Greystone Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

NELLIE T. PIELERT

3. (b) Social Security Number

None4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife Robert C. Pielert7. Birth date of deceased (mo., day, yr.) May 22, 18658. AGE: 83 Years 4 Months 15 Days hrs. min.9. Birthplace Baltimore Md
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name James C. Smith13. Birthplace England14. Maiden name Catherine Dowling15. Birthplace Phil Pa16. Informant Irvin W. SponzlerAddress 1242 Greystone Road17. Burial Burial Date thereof Oct 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemLocation Woodlawn, Md18. Funeral director Robert A. B. M. WaltersAddress Pratt & Stricker St19. Oct 11 19 48 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 19 48 at 10³⁰ P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1945 to Oct 7 19 48
and that I last saw him alive on Oct 5 19 48Immediate cause of death Respiratory failureDue to Hypertensive heart -senile cardiovascularDue to renal disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Shorofsky M.D.Address 601 N. Moore St Date signed 10/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

10242

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 8 N. Bruce Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war SAW

3. (a) FULL NAME

LOUIS J. POLLOCK

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Widower

7. Birth date of deceased (mo., day, yr.)

March 1873

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

75

7

hrs.

min.

9. Birthplace

Ellicott City, Md.

(Town, county, and state)

10. Usual occupation

Unemployed

11. Industry or business

FATHER

12. Name

Louis J. Pollock

13. Birthplace

Maryland

MOTHER

14. Maiden name

Laura Gardner

15. Birthplace

Maryland

16. Informant

Clinical Records, Vets. Adm. Hospital

Address

Fort Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Oct 11, 1948

(month) (day) (year)

Cemetery or crematory

Baltimore National Cemetery

Location

Baltimore, Md.

18. Funeral director

Charles R. Low

Address

802 Madison Ave., Baltimore, Md.

19.

(Date read by registrar)

19

48

10/9

x8

R.W. Hedrick

Reg.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948 7:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 4, 1948 to October 8, 1948and that I last saw him alive on October 8, 1948

Immediate cause of death

DILATION OF RIGHT SIDE OF HEART

DURATION

Unknown

Due to

Due to

Other conditions

Hypertrophy of ProstateUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stanley K. Steinbach, M.D.

M. D. or other

Address

VAH. Fort Howard, Md.

Date signed

10-3-48

CERTIFICATE OF DEATH

Registered No. 10243

1. PLACE OF DEATH: Co.
 (a) Baltimore Co., Maryland
 (b) Street address Wade Ave. Catonsville Md.
 (c) Hospital or institution:
Spring Grove Hospital
 (d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr. 8 Mo.
 (e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr. 8 Mo.

2. USUAL RESIDENCE OF DECEASED:
 (a) State Md. (b) County Charles
 (c) City or town Marbury
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. _____ (If rural give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3 (a) FULL NAME NOBLE POSEY

3 (b) If veteran, name war Unknown 3 (c) Social Security Account No. Unknown

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Unknown 6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) ? ? 1884

8. AGE: Years 64 Months ? Days ? If less than one day _____ hr. _____ min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual Occupation farmer

11. Industry or business Farm

12. Name Unknown Posey

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Spring Grove State Hosp.

(b) Address Records

17 (a) Burial (b) Date thereof 11/2/48
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Family Cemetery

Location Near Waldorf Md.

18 (a) Funeral director Hunt & Ryan

(b) Address Waldorf Md.

19 (a) _____ (b) Thurston Williams, M.D.
 Registrar

OCT 31 1948

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948, at 2.35PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A.S.C.V.D.

Due to _____

Other Conditions _____

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury _____ at _____ M.

(b) Where did injury occur? _____

(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____

(d) Means of injury Car

23. Signature Emil C. Ryan M.D.

Date signed October 30, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 94a

10244

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltoCity or town Violetsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

3647 Hensline Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Violetsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 3647 Hensline Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William E. Rau Jr.

3. (b) Social Security Number

213-10-7066

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary A. Rau

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

May 10th 1890

8. AGE:

Years

Months

Days

If less than one day

58429hrs.min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

Self

12. Name

John Conrad Rau

13. Birthplace

Balto. Md.

14. Maiden name

Amelia DeMuth

15. Birthplace

Balto. Md.

16. Informant

Wm E. Rau Jr

Address

628 Washington Ave

17. (Burial, cremation, or removal. Which?)

Date thereof

10/12/48
(month) (day) (year)

Cemetery or crematory

London Park

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19.

10/11

19

48G. W. Helms

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1948 at 11¹⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 A.M.1948 to October 9 1948and that I last saw him alive on October 9 1948

Immediate cause of death

Acute Coronary Occlusion

DURATION

2 1/2 hrs

Due to

Hypertensive Cardio Vascular10 yrs

Due to

Other conditions

Left Hemiplegia10 yrsAngina Pectoris
(Include pregnancy within 8 months of death)8 mos

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Earl Pass MD

M. D. or other

Address

4001 Wilkens AveDate signed 10-11-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10245

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Ind
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 monthsHospital, institution, or street address where death occurred:
Masonic Home Cockeysville Ind

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2700 Chumers Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lilly S. Reckling

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Jeremiah C. Reckling

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 - 18678. AGE: Years 81 Months 6 Days 28 If less than one day hrs. min.9. Birthplace Aberdeen Maryland
(Town, county, and state)10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Ephraim Price13. Birthplace ?MOTHER 14. Maiden name Justina Bruesler15. Birthplace Pa.16. Informant Laura M. Schroeder Pr C. P. TiptonAddress Masonic Home, Cockeysville Ind17. Burial (Burial, cremation, or removal, Which?) Date thereof 10-16-48
(month) (day) (year)Cemetery or crematory New Freedom PaLocation ?18. Funeral director Wm CookAddress St. Paul & Preston St.19. 11-3 19 48 L. M. Schroeder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 19 48 at 4:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 4 19 48 to Oct. 14 19 48and that I last saw him alive on Oct. 14 19 48Immediate cause of death Heart failure DURATION 10 daysDue to Arteriosclerotic heartDisease UnknownDue to Senile Arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Keen M. D.Address Cockeysville Ind Date signed 10-14-48

RECEIVED
NOV 4 1948
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10246

Reg. Dist. No. **XX**

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Fort Howard, Md.

How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CCG

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5718 Ritchie Highway
(If rural, give LOCATION)

2. (a) If veteran, name war WW-2 ✓

3. (a) FULL NAME

CHARLES EDWARD RICE

3. (b) Social Security Number

129-01-9407

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife single

7. Birth date of deceased (mo., day, yr.) May 5, 1907 6. (c) If alive, give age 48 years

8. AGE: Years 41 Months 5 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name Lewis Rice

13. Birthplace Baltimore, Maryland

14. Maiden name Liddie Benson

15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial BALTIMORE NATIONAL CEMETERY

Date thereof 11/2/48
(month) (day) (year)

Cemetery or crematory BALTIMORE NATIONAL CEMETERY

Location BALTIMORE, MARYLAND

18. Funeral director Charles P. Law

Address 802 Madison Avenue

19. 11/3 xs AW. Hedrick
(Date rec. by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 19 48, at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 48 to Oct. 30 19 48 and that I last saw him alive on October 30 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION 9 mos.

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. F. Scullio M. D. or other

Address VAH FT. Howard, Md. Date signed 10-30-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10247

37

1. PLACE OF DEATH:

County Baltimore
City or town Cockeysville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
Masonic Homes - Cockeysville Md.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3004 Westwood St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Edward Martin Rice

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Estelle M. Rice
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) 8-30-1864

8. AGE: Years 84 Months 1 Days 11 If less than one day hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual occupation Ex-rayist - Photographer

11. Industry or business Johns Hopkins Hospital

12. Name Samuel Edwin Rice

13. Birthplace ?

14. Maiden name Annie C Bentley

15. Birthplace Connecticut

16. Informant Laura M. Schroeder per C.P. Tipton

Address Masonic Homes Cockeysville Md

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof October 13 1948
(month) (day) (year)

Cemetery or crematory Greenmount Cemetery

Location Baltimore Md.

18. Funeral director Wm Cook

Address St Paul + Preston Sts.

19. October 11 1948 Laura M. Schroeder
(Date rec'd by registrar) (Signature)

per C.P. Tipton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1948 at 5 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1948 to Oct 11 1948

and that I last saw him alive on 9 October 1948

Immediate cause of death Cerebral Accident DURATION 7 days

Due to Arterio sclerosis Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D. M. D. or other

Address Cockeysville, Md. Date signed 10-11-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



1864-30

11-1-48

11-1-48
17 b

VS A15 9.45.15N

MARGIN RESERVED FOR BINDING

M

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10248
48

932

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 110 days

Hospital, institution, or street address where death occurred:

VAH, Fort Howard, Maryland

How long in hospital or institution? 110 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Beth

City or town Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 780 Clarksouth Place
(If rural, give LOCATION)

2.(a) If veteran, name war WW

3. (a) FULL NAME

ALONZO T. ROBINS

3. (b) Social Security Number

216-03-1996

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. MARGARET ROBINS

7. Birth date of deceased (mo., day, yr.) May 10, 1892 6.(c) If alive, give age 50 years

8. AGE: Years 56 Months 5 Days 12 If less than one day hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Cabinet Worker

11. Industry or business

12. Name Edwin Robins

13. Birthplace Virginia

14. Maiden name Emma Redd

15. Birthplace Virginia

16. Informant Clinical Records, Vet. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Burial Date thereof Oct 26 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Baltimore, Maryland

18. Funeral director Ullrich Funeral Home

Address 2008 Orleans Street, Balto., Md.

19. 10/25/48 A. B. French
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 19 48 at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 48 to October 22 19 48

and that I last saw him alive on October 22 19 48

Immediate cause of death

ARTERIOSCLEROTIC HEART DISEASE

WITH MYOCARDIAL FAILURE AND

PLEURAL EFFUSION, RIGHT;

CORONARY ARTERIOSCLEROSIS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. B. French M. D. or other

Address VAH, Fort Howard, Md. Date signed 10-22-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH ^{93d}

10249

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Oella
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hollow Rd n Glen an

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Oella
(If outside city or town limits, write RURAL and give nearest town)Street No. Hollow Road n Glen an
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James T Robinson

3. (b) Social Security Number

213-10-0431 A

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widower

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1948 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Acute Cardiac Failure

Due to

Cardiovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

See Dr. Kieffer

SIGNATURE

M. D. or other

Address 1010 Leeds an Date signed 10-1-486. (b) Name of husband or wife Cornelia W Robinson

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

March 10 1879

8. AGE:

Years

Months

Days

If less than one day

69621

hrs.

min.

9. Birthplace

Baltimore Co. Md

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Baltimore Transit

12. Name

Thomas Robinson

13. Birthplace

Md

14. Maiden name

Martha Wheatley

15. Birthplace

Md

16. Informant

Andrew James Robinson

Address

Oella Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 10-5-48

(month) (day) (year)

Cemetery or crematory

Moreland Memorial

Location

Baltimore Md

18. Funeral director

F. C. Higinbotham

Address

Ellicott CityMd19. 10/4

(Date received by registrar)

19 48A. W. Hedrick
Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10250

Reg. Dist. No. 44

1. PLACE OF DEATH
 County Balto.
 City or town Essex Balto 21.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Marlyn Ave + Brook Rd
 How long in hospital or institution? 2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Same
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

George F. Rose

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Olga Rose

7. Birth date of deceased (mo., day, yr.) July 25/1887 6.(c) If alive, give age..... years

8. AGE: Years 61 Months 2 Days 17 If less than one day..... hrs. min.

9. Birthplace Balto, City,
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Job work for self.

12. Name John Rose

13. Birthplace Germany

14. Maiden name Elizabeth ?

15. Birthplace Germany

16. Informant Mrs. Olga Rose (wife)

Address same

17. Burial Date thereof Oct. 14 - 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Schwartz's

Location O'Donnell St.

18. Funeral director John G. Connelley

Address 418 Eastern Ave. East 21

19. 10/12/48 19.....
 (Date rec'd by registrar) Registrar John G. Connelley

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 6³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death..... DURATION.....

Due to.....

Due to.....

Other conditions.....

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RECEIVED

OCT 16 1948.

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

10251

1. PLACE OF DEATH:

County Baltimore

City or town Chesapeake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Int. Pleasure Sanatorium

How long in hospital or institution? 23 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 620 K. St. Mont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hattie Rosenblatt

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Max Rosenblatt

7. Birth date of deceased (mo., day, yr.)

May 30, 1875 (1875)

6. (c) If alive, give age

76 years

8. AGE:

Years

Months

Days

If less than one day

73

hrs.

min.

9. Birthplace

Russia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Aaron Chart

13. Birthplace

Russia

14. Maiden name

Plotter ?

15. Birthplace

Prussia

16. Informant

Max Rosenblatt

Address

620 K. St. Mont Ave. Balt, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

10-12-48
(month) (day) (year)

Cemetery or crematorium

Location

St. Mary's Mt. Carmel

18. Funeral director

Address

Jack Kewas Inc
2100 Eutaw Place

19.

10/12 48
(Date rec'd by registrar)

19.

48

ASW Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1948 at 11:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 24 1948 to Oct 11 1948

and that I last saw her alive on October 11 1948

Immediate cause of death

Myocardial Failure

Due to

Pulmonary Tuberculosis

DURATION

4 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results See advanced Pulmonary Tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

B. Puderis MD

M. D. or other

Address Chesapeake, Md Date signed Oct 11/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

10252

1. PLACE OF DEATH

County Baltimore
 City or town 114 Honey Suckle Court
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Turners Station
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 114 Honey Suckle Court
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Nadine E. Ross

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 31 - 1927

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

21314

hrs.

min.

9. Birthplace

Baltimore, Md
(Town, county and state)

10. Usual occupation

School Girl

11. Industry or business

FATHER

12. Name

Thomas Ross

13. Birthplace

Maryland

MOTHER

14. Maiden name

Eva Morris

15. Birthplace

Maryland

16. Informant

Eva Ross Ayers

Address

114 Honey Suckle Court

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct 10 - 48
(month) (day) (year)

Cemetery or crematory

Mt Auburn

Location

West Port

18. Funeral director

W. Brooks Funggold

Address

1463 N. Carey St

19.

(Date recd by registrar)

19

10/84810/810/810/810/8

Registrar

23. SIGNATURE

William L. Brown M.D. or other
 Address 423 N. P. Johnson Date signed 10-6-48

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 19 48 at 4:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 48 to Oct 7 19 48 and that I last saw him alive on Oct 6 19 48

Immediate cause of death Pneumonia DURATION

Due to Strep infection

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

William L. Brown M.D. or other

Address 423 N. P. Johnson Date signed 10-6-48

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A16

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10253

30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 years, 2 months, 16 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 5 years, 2 months, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1324 East Lanvale Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Sency E. Sanner

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Alexander Sanner
 7. Birth date of deceased (mo., day, yr.) May 8, 1880?
 6. (c) If alive, give age 68 years
 8. AGE: Years 68 Months 5 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Pennsylvania
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name John Stemler
 13. Birthplace Germany
 14. Maiden name Theresa Merreck
 15. Birthplace Austria

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial Date thereof 10/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral Cem.
 Location Frederick Rd.
 18. Funeral director John F. Senny Inc
 Address 745 Light St.
 19. 10/20 48 A. H. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 19 48 at 5:10 a
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 19 43 to October 19 19 48
 and that I last saw him/her alive on October 19 19 48

Immediate cause of death Terminal pneumonia
 DURATION 2 weeks
 Due to Hypertensive cardiovascular disease Indefinite
 Due to Arteriosclerosis, generalized "
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury _____ Injured at work? Struck by car, m.o.
 23. SIGNATURE Isadore Turk M.D. M. D. or other
Catonsville-28, Md. Date signed 10-19-48
 Address _____

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10254

FILM No. G 118 NOV 10 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

106 Venturay

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto

City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Venturay
(If rural, give LOCATION)

2.(a) if veteran, name war.

3. (a) FULL NAME

Rita Marie Schweigert

3. (b) Social Security Number

4. Sex

F

5. Color or race

Wh.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of
deceased (mo., day, yr.)

May 6 - 1948

8. AGE:

Years

Months

Days

it less than one day

5

24

21

hrs.

min.

9. Birthplace

Balto, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Edward Schweigert

13. Birthplace

Balto Md

14. Maiden name

Rita Marie Cyphert

15. Birthplace

Balto Md.

16. Informant

Mr. Ed. Schweigert

Address

106 Venturay Balto Md

17. (Burial, cremation, or removal. Which?)

Date thereof

Oct 28-48
(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

German Hill Rd.

18. Funeral director

John G. Connolly

Address

418 Eastern Ave.

19.

Oct 28 19 48
(Date rec'd by registrar)

19

48

John G. Connolly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 19 48 at 7:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19

Immediate cause of death

Asphyxiation

Due to

Head became entangled in

Due to

bed clothes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

True Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/27/48

Where did injury occur? Dundalk - Barr Co
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Head became entangled in bed clothes Injured at work? No

23. SIGNATURE

M. B. P. Davis M.D. Barr Co. Md. or other

Address Dundalk Date signed 10/28/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and

RECEIVED
NOV 5 1948
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10255

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... **Baltimore**
 City or town... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **2 months, 16 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? **2 months, 16 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... **Maryland** County.....
 City or town... **Baltimore-12**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **505 Arlington Avenue**
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Reid
Ethel/Shoemaker

3. (b) Social Security Number

215-07-8178

4. Sex **female** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **widowed**
 6. (b) Name of husband or wife **Charles^P/Shoemaker**
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **March 26, 1871**
 8. AGE: Years **77** Months **7** Days **2** If less than one day..... hrs. min.

9. Birthplace **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation **Clerk U. S. F. & G.**
 11. Industry or business **Office Holt**
 12. Name **William Reid**
 13. Birthplace **Matthews Co., Va.**
 14. Maiden name **Harriet Ackland**
 15. Birthplace **Va.**

16. Informant **Hospital records**
 Address **Catonsville-28, Maryland**
 17. Burial **10/30/48**
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory **Loudon Park Cem.**
Balto., Md.
 Location **WM. J. TICKNER & SONS**
 18. Funeral director **Balto., Md.**
 Address

19. **10-29** 19 **48**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **October 28** 19 **48** at **8:15 a.m.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **October 12** 19 **46** to **October 28** 19 **48**
 and that I last saw him/her alive on **October 28** 19 **48**

Immediate cause of death **Chronic myocarditis** DURATION **Indef.**

Due to **Hypertensive cardiovascular disease** **Indef.**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury **Isadore Tuerk, m.o.** Injured at work?

23. SIGNATURE **Isadore Tuerk, M.D.** M. D. or other

Address **Catonsville-28, Maryland** Date signed **10-28-48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. I will correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age as especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10256

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, 13 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Seton Institute 1535 Cole St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Rachel Shoemaker

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____ 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1870
 8. AGE: Years 78 Months ? Days ? It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)

10. Usual occupation Unknown

11. Industry or business ?

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial ? Date thereof 11-8-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Grove Hospital

Location Catonsville 28, Md.

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Md.

19. 11-8 19 48 V.E. Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 19 48 at 3:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 48 to October 21 19 48 and that I last saw her alive on October 21 19 48

Immediate cause of death Cardiac collapse DURATION 8 days

Due to Arteriosclerotic heart disease Indefinite

Due to Arteriosclerosis, generalized "

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

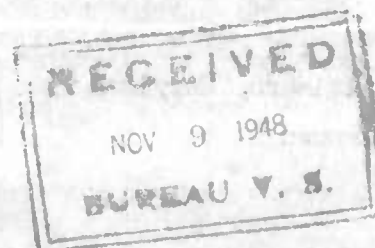
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 11-4-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10257

1. PLACE OF DEATH:

County Baltimore
City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
How long in hospital or institution? 45 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1033 Maldeis Street
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME

HOWARD F. SMITH

3. (b) Social Security Number

Un known

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1-26-98 6. (c) If alive, give age _____ years

8. AGE: Years 50 Months 8 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name David Smith

13. Birthplace Maryland

14. Maiden name Aireybell Bamber

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof 10/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Everett Armacost

Address Armocost Funeral Home

Balto., Md.

19. 10/19 48 W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1948, at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 1948, to October 18, 1948

and that I last saw him alive on October 18, 1948

Immediate cause of death Myocardial Insufficiency DURATION 2-1/2 yrs.

Due to Rheumatic heart disease 21 Yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE H.C. Manough

H.C. MANAUGH, M.D. Chief Prob. Ser

Address VAH, Ft. Howard, Md. Date signed 10-18-48

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
 County Balto.
 City or town Sparrows Point
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
921 H St
 How long in hospital or institution? 22 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Same County Same
 City or town Same
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Same
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rosa Ozelle Smith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Thos. B. Smith
 7. Birth date of deceased (mo., day, yr.) Dec 21 / 1891
 6. (c) If alive, give age _____ years
 8. AGE: Years 56 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Olin N.C.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business at home
 FATHER 12. Name Thos. Albert Campbell
 13. Birthplace N.C.
 MOTHER 14. Maiden name Unknown
 15. Birthplace N.C.
 16. Informant Mrs. B. Smith (husband)
 Address above

17. Burial Date thereof Oct. 14, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Moreland Memorial Park
 Location Taylor Ave., Balto., Co.
 18. Funeral director Roland J. Fisher
 Address 2112 Dundalk Ave.
 19. Oct 14 - 48 D. J. Harbor
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1948 at 10³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____
 and that I last saw him alive on _____ 19____

Immediate cause of death Cerebral Hemorrhage
 DURATION 25 minutes

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

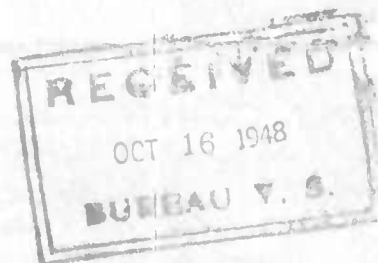
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE D. J. Harbor M.D.Address 2112 Dundalk Ave. Date signed 10/14/48

914 D



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10259

Reg. Dist. No. 32

1. PLACE OF DEATH

County Baltimore
 City or town Stephenson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:
Valley Rd, Stephenson, Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Stephenson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Valley Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Catherine Smith

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced m.
 6.(b) Name of husband or wife Wilfred Smith
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) 20 March 1888

8. AGE: Years 63 Months 9 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER 12. Name George W. Stephens

13. Birthplace Baltimore Md.

14. Maiden name Ellen C. Stephens

15. Birthplace Baltimore Md.

16. Informant Wilfred Smith

Address Valley Rd, Stephenson Md

17. BURIAL Date thereof Nov 2-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or DRUID RIDGE

Location PIKESVILLE

18. Funeral director CHAS. F. EVANS & SON

Address 118 W. Mt. Royal Ave

19. 11-1 RP Am...
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Oct 1948 at 10:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Oct 1948 to 31 Oct 1948 and that I last saw her alive on 31 Oct 1948

Immediate cause of death Cardiorespiratory failure

Due to Carcinoma of cervix with metastases 3 yrs

Due to _____

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Paula Royce M.D. M. D. or other

Address Pikesville Md Date signed 31 Oct 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10260

38

93d

1. PLACE OF DEATH:

County Baltimore
 City or town Baltimore-Rogers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
85 Dunkirk Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore - Rogers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 85 Dunkirk Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

LAWRENCE ANDREW SNYDER

3. (b) Social Security Number

216-12-0499

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Marguerite L.
 6. (c) If alive, give age 52 years
 7. Birth date of deceased (mo., day, yr.) June 29, 1885
 8. AGE: Years 63 Months 3 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation _____
 11. Industry or business Transfer Company
 12. Name Andrew Snyder
 13. Birthplace Baltimore, Md.
 14. Maiden name Clara Weaver
 15. Birthplace Baltimore, Md.

16. Informant Mrs. Marguerite L. Snyder
 Address 85 Dunkirk Road - 12
 17. Burial 11/1/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parkwood Cemetery
 Location Baltimore, Maryland
 18. Funeral director HENRY SANDER & SONS, INC.
 Address NORTH AVE. & BROADWAY
 19. Oct 30 1948 A.W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1948 at 2 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-Jan 1946 to 28-Oct 1948
 and that I last saw him alive on 27-Oct- 1948

Immediate cause of death Cerebral Embolus
 Due to Arteriosclerotic Cardiovascular Disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Chas W. Edwards M.D.
2746 Alameda M.D. or other
 Address _____ Date signed 28-Oct-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10261

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... *Baltimore*
 City or town..... *Catonsville*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

..... *3 University Ave.*
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *md.* County..... *Balto.*
 City or town..... *Catonsville*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... *3 University Ave.*
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

..... *Ethel Spiegel*

3. (b) Social Security Number

4. Sex..... *F* 5. Color or race..... *W* 6.(a) Single, married, widowed, or divorced..... *Widowed*

6.(b) Name of husband or wife..... *William Spiegel*

7. Birth date of deceased (mo., day, yr.)..... *March 31, 1889* 6.(c) If alive, give age..... years

8. AGE: Years..... *59* Months..... *6* Days..... *17* If less than one day..... hrs. min.

9. Birthplace..... *Maryland*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... *John T. Levenberger*
 13. Birthplace..... *md.*

MOTHER 14. Maiden name..... *Katherine Levenberger*
 15. Birthplace..... *md.*

16. Informant..... *Mrs. Mae Bellinger*
 Address..... *2107 Mc Henry St.*

17. Burial Date thereof..... *10-21-48*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Cathedral*
 Location..... *Baltimore*

18. Funeral director..... *George A. Forley*
 Address..... *Fulton Ave. + Fayette St.*

19. *10-20* 19 *48* *J.E. Harry*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *October 18* 19 *48* at *9:00 A.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 29* 19 *48* to *Oct 18* 19 *48*
 and that I last saw him alive on *Oct 17* 19 *48*

Immediate cause of death..... *Cerebral Hemorrhage* DURATION..... *10 H 48*

Due to..... *General Arteriosclerosis*
Hypertension 13 years

Due to..... *Cerebral Hemorrhage* 24/1943

Other conditions..... (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Eliot W. Johnson MD* M. D. or other
5432 Frederick St. 14/19/48
 Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 21 1948

BUREAU V. S.

CERTIFICATE OF DEATH 165

Registered No. 43

1. PLACE OF DEATH:

(a) Baltimore City, Maryland
 (b) Street address Silver Spring Road
 (c) Hospital or institution Fullerton, Balto. Co.

(d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.
 (c) City or town Fullerton
 (If outside city or town limits, write RURAL and give town)
 (d) Street No.
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country.

3 (a) FULL NAME

BABY STARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day
 hr. (10?) min.

9. Birthplace
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (b) Date thereof
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

18 (a) Funeral director

(b) Address

19 (a) 12/20/48 (b) Date rec'd by registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1948, at 12:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-26-48 at 2:35 A. M.

(b) Where did injury occur? Silver Spring Road

(c) Did injury occur at home, on farm, industrial place, in public place? Fullerton, Maryland

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Strangled

23. Signature E. H. Ryan M.D.

Date signed 10-26-48 Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10262

Reg. Dist. No. 42

1. PLACE OF DEATH:

County Balto.City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1729 Winans Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)Street No. 1729 Winans Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

JOSEPH ANDREW STOCK

3. (b) Social Security Number

none

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
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6. (b) Name of husband or wife Marie A. Stock7. Birth date of deceased (mo., day, yr.) March 14, 1893
6. (c) If alive, give age years

8. AGE: Years <u>55</u>	Months <u>7</u>	Days <u>17</u>	If less than one day hrs. min.
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9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Inspector11. Industry or business Balto. Co.12. Name Andrew Stock13. Birthplace Germany14. Maiden name Katherine Lortz15. Birthplace Germany16. Informant Mrs. Marie A. StockAddress 1729 Winans Ave., Halethorpe, Md.17. Burial Date thereof 11/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park Cem.Location Baltimore, Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 11/2 xs A. W. Hedrick
(Date rec'd by registrar) 19. 48 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 19 48, at 7:00 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1941 to Oct 31, 19 48
and that I last saw him alive on Oct 31, 19 48Immediate cause of death Cerebral ThrombosisDue to Ch. Myocarditis
& hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Tickner M. D.Address 1729 Selma Ave. Date signed Nov 1-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10263

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

1. PLACE OF DEATH:

County Baltimore

City or town Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

SALLIE B. TARNING

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Harry

8.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1885

8. AGE: Years Months Days If less than one day
63 0 9 _____ hrs. _____ min.

9. Birthplace Pa
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Harry Tarning

Address Chase, Md.

17. Removal Lebanon Date thereof 10/5/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lebanon

Location Lebanon, Pa.

18. Funeral director William Cook, Inc.

Address 1217 St. Paul St.

19. 10/4 48 R.W. Hedrick
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1948, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1946 to October 2 1948

and that I last saw her alive on October 2 1948

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations above

Date of op. Aug 1946 & Oct 1947

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James F. White M.D.

422 Eastern Ave M. D. or other

Address Baltimore 21, Md. Date signed 10/7/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

10264

1. PLACE OF DEATH
County Balto
City or town Madison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Madway Mrs Cobine
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For born infants give residence of mother)
State Pa County Lancaster Co
City or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 233 S. Marshall St
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Robert D Terrel

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Betty B. Rancroft
7. Birth date of deceased (mo., day, yr.) April 5 - 1918 6.(c) If alive, give age 30 years

8. AGE: Years 30 Months 4 Days 5 If less than one day
hrs. min.

9. Birthplace Grove Ohio
(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Champion Chemical Co.

12. Name William E. Terrel

13. Birthplace Ohio

14. Maiden name Kathryn Holt

15. Birthplace Ohio

16. Informant Mrs. Betty Terrel

Address 233 S. Marshall St. Lm. Pa.

17. Transportation Date thereof Oct. 21 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Logan, Ohio

Location John E. Connelley

18. Funeral director John E. Connelley

Address 418 Eastern Ave. Pikes Md.

19. Oct. 21st 1948 1948
(Date rec'd by registrar)

20. Registrar W. E. Connelley

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1948 at 7:20 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Over come by smoke

Due to supper

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/20/48

Where did injury occur? Madison Pa. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Chair burned Injured at work? no

23. SIGNATURE Wm. Connelley M.D.

Address Deputy Medical Examiner

Balto Co. Maryland Date signed 10/20/48

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10265

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1102 Magruder Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1102 Magruder Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Bessie Pierpont Thurn

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Herbert J. Thurn

7. Birth date of deceased (mo., day, yr.) October 9, 1897 6. (c) If alive, give age _____ years

8. AGE: Years 51 Months - Days 7 It less than one day _____ hr. _____ min.

9. Birthplace Baltimore County, Md.
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business At Home12. Name Frank F. Pierpont13. Birthplace Baltimore County, Md.14. Maiden name Laura S. Zimmerman15. Birthplace Baltimore County, Md.16. Informant Mr. Herbert J. ThurnAddress 1102 Magruder Ave., Catonsville

17. Burial Date thereof Oct. 20, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Md.18. Funeral director Willis L. LumsdenAddress 4510 Liberty Heights Ave.19. 10-20-48 VE Harry

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 48 at 10:07 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 July 19 48 to 16 Oct 19 48

and that I last saw him alive on 16 Oct 48 19 48Immediate cause of death Cardio-Respiratory failure DURATIONDue to severe anemiaDue to leukemic leukemia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE William J. Bryson M. D. or otherAddress 846 W. 36th St. Date signed 18 Oct 48

RECEIVED

OCT 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

10266

1. PLACE OF DEATH:

County Balto.City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Glenn Falls Road
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Winfield Scott Uhler

3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1888

8. AGE:

Years 60Months 6Days 15

If less than one day

hrs. min.

9. Birthplace

Balto. Co.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Charles W. Uhler

13. Birthplace

Balto. Co.

MOTHER

14. Maiden name

Sallie Leory

15. Birthplace

Balto Co.

16. Informant

Mrs. Elmer Uhler

Address

Reisterstown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 3, 1948
(month) (day) (year)

Cemetery or crematory

Pleasant Hill

Location

Balto. Co.

18. Funeral director

Address

Reisterstown, Md.

19.

Nov. 3, 1948
(Date rec'd by registrar)Mary B. Eline
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1948 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-24 1948 to 10-31 1948and that I last saw him alive on 10-30 1948

Immediate cause of death

Rapid Hemorrhagic
nephritis

DURATION

3 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. D. Caples

M. D. or other

Address

Reisterstown, Md.Date signed 11-31-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 8 1940

BUREAU V. S.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 10267

1. PLACE OF DEATH: Found: Chesapeake Bay in the vicinity of 7th Knoll
(a) Baltimore City, Maryland
(b) Street address: Washed ashore at Sparrows Pt.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U (b) County
(c) City or town N
(If outside city or town limits, write RURAL and give town)
(d) Street No. N (If rural give location)
(e) Citizen of foreign country U (Yes or No)
If yes, name country N

3 (a) FULL NAME UNKNOWN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male 5. Color or race White 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Adult Months U Days N If less than one day
hr. min.

9. Birthplace N (Town, county, and state)

10. Usual Occupation U

11. Industry or business W

12. Name N

13. Birthplace U

14. Maiden Name K

15. Birthplace N

16 (a) Informant O

(b) Address N

17 (a) Burial (b) Date thereof Oct. 15, 1948
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. Co. Home
Location Texas, Balto. Co.

18 (a) Funeral director Roland L. Fisher

(b) Address 2112 Dundalk Ave.

19 (a) 10/15/48 (b) DW Hedrick
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 19 48, at 2:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Means of injury Undetermined
Found drowned

Due to (12/4/48)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

Found: (a) Date of injury 10-9-48 at 2:30 P. M.

(b) Where did injury occur Found: Sparrows Pt. nr. 7th Knoll

(c) Did injury occur at home, on farm, industrial place, in public place? Washed ashore While at work? No

(d) Means of injury Found drowned

23. Signature George H. Merrill M.D.

Date signed 10/10/48 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10268

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 months
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... Catonsville 28, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106 E. Hamburg Street, Baltimore
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME

Emma Vettters

3. (b) Social Security Number

215-12-8710

4. Sex..... female
 5. Color or race..... white
 6.(a) Single, married, widowed, or divorced..... married

6.(b) Name of husband or wife..... John Vettters

7. Birth date of deceased (mo., day, yr.)..... May 1, 1899
 6.(c) If alive, give age..... 60 years

8. AGE: Years..... 49 Months..... 5 Days..... 11
 If less than one day..... hrs. min.

8. Birthplace..... Virginia
(Town, county, and state)10. Usual occupation..... housewife11. Industry or business..... home12. Name..... Jacob Doms13. Birthplace..... Virginia14. Maiden name..... Virginia Forbis15. Birthplace..... Virginia16. Informant..... Hospital records

Address

17. Burial Date thereof..... 10/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Balto NationalLocation..... Frederick Rd18. Funeral director..... John F. Henry, IncAddress..... 715 Light St.19. Oct 14 1948 Registrar..... G. W. Hefner
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 12, 1948 at 2:20 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 7, 1948 to October 12, 1948and that I last saw him alive on October 12, 1948Immediate cause of death..... Left lower lobar pneumonia
DURATION..... 36 hoursDue to..... Acute exacerbation chronic glomerular nephritis
4 daysDue to..... Chronic hypertensive cardiovascular disease
indef.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: --

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Isadore Tuerk, M.D.

M. D. or other

Address..... Spring Grove State HospitalDate signed..... 10-12-48Address..... Balto. 28

PLEASE WRITE PLAIN, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10269
30

1. PLACE OF DEATH:

County..... **Baltimore**
 City or town..... **Catonsville**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **12 days**
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution?..... **12 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **Baltimore-16**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **1801 Ashburton Street**
 (If rural, give LOCATION)
 2. (a) If veteran, name war..... ✓

3. (a) FULL NAME

Beulah A. Walter (Beulah Adel Walter)

3. (b) Social Security Number

4. Sex..... **female**
 5. Color or race..... **white**
 6. (a) Single, married, widowed, or divorced..... **married**
 6. (b) Name of husband or wife..... **Virgil David Walter**
 6. (c) If alive, give age..... **55** years
 7. Birth date of deceased (mo., day, yr.)..... **July 17, 1890**
 8. AGE: Years..... **58** Months..... **3** Days..... **10** If less than one day..... hrs. min.

9. Birthplace..... **Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Housewife**
 11. Industry or business..... **Home**
 12. Name..... **Henry Bolte**
 13. Birthplace..... **Germany**
 14. Maiden name..... **Sarah Leiplein**
 15. Birthplace..... **Maryland**

16. Informant..... **Hospital records**
 Address..... **Catonsville-28, Maryland**
BURIAL
 17. (Burial, cremation, or removal, Which?) Date thereof..... **10/31/48**
 (month) (day) (year)
 Cemetery or crematory..... **ST. PAUL**
BALTO. COUNTY (Arcadia)
 Location..... **WM. J. TICKNER & SONS**
 18. Funeral director.....
 Address..... **BALTO., MD.**

19. **10/27/48** Registrar
 (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 27** 19. **48** at **10:22 pm**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 15 19. **48** to **October 27** 19. **48**
 and that I last saw her alive on **October 27** 19. **48**

Immediate cause of death..... **Fibro-sarcoma with secondary infection**
 DURATION..... **indefinite**

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results..... **none**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....
Broken Truck, N.D.

23. SIGNATURE..... **Isadore Tuerk, M.D.** M. D. or other.....
 Address..... **Catonsville-28, Md.** Date signed..... **10-28-48**

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10270

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 8 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 6 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 811 Main Street
(If rural, give LOCATION)
2. (a) If veteran, name war ☒

3. (a) FULL NAME

Mary Ann Webb

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widowed

6. (b) Name of husband or wife Walter Whitefield Webb

7. Birth date of deceased (mo., day, yr.) September 17, 1870

8. AGE: Years Months Days If less than one day
78 1 4 hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Home Missionary

11. Industry or business Church

12. Name ? Barker

13. Birthplace Virginia

14. Maiden name Virginia ?

15. Birthplace Virginia

16. Informant Hospital records

Address Catonsville-28, Maryland

17. BURIAL Date thereof 10/23/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory WESTERN

Location EDMONSON AVE

18. Funeral director JOHN F. DENNY, INC.

Address 715 LIGHT ST

19. 10/22 78 RD Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 19. 48 at 3:05 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death Acute Cardiac Failure

Due to Arteriosclerosis

Other conditions Generalized Atherosclerosis

Heart disease

fracture of left femur (neck)

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of OCT 5, 48

Where did injury occur? Catonsville Bath and (City or town) (State)

Injured at home, farm, industry, public place (where?) Knocked down on floor

Means of injury by another patient Injured at work? no

23. SIGNATURE Dr. Frank Kieffer Registered

Address 1010 Leedesan Date signed OCT 24, 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

42 Edgewater

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. 42 Edgewater
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fredrick W. Wehmeyer Jr.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Dec. 14th 1917

8. AGE:

30

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

New York State
(Town, county, and state)

10. Usual occupation

Medical Doctor

11. Industry or business

FATHER

12. Name

Fred. W. Wehmeyer

13. Birthplace

Germany

MOTHER

14. Maiden name

Adela Conners

15. Birthplace

Italy

16. Informant

Address

S. Harley J. Gross
Middle River

17.

(Burial, cremation, or removal. Which?)

Date thereof

Oct. 12-48
(month) (day) (year)

Cemetery or crematory

London Park

Location

Fredrick Rd

18. Funeral director

Address

John E. Connell

19.

(Date rec'd by registrar)

John E. Connell
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948 at 8³⁰ P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death

Haemulation by hanging

DURATION

5-6 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10/8/48Where did injury occur? Middle River, Md
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury hanging in bathroom Injured at work? no

23. SIGNATURE

John E. Connell Date signed 10/14/48

RECEIVED
OCT 16 1942
BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10272

1. PLACE OF DEATH

County BaltimoreRegistration Dist. No. 940Village or City HurstableighNo. Charles & Woodbrook Lane

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 18 yrs.How long in U. S. If of foreign birth? 18 yrs. 0 mos. 0 ds.2. FULL NAME Alva Fisher Wheeler(a) Residence: No. Charles & Woodbrook Lane St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (<i>write the word</i>) <u>Married</u>
--------------------	------------------------------	---

5e. If married, widowed, or divorced
HUSBAND of Robert H. Wheeler
(or) WIFE of6. DATE OF BIRTH (month, day, end year) June 10, 1899

7. AGE	Yaars	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
<u>49</u>	<u>4</u>	<u>4</u>	<u>2</u>	

OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.	<u>none</u>
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	<u>***</u>
	10. Date deceased last worked at this occupation (month and year)	<u>***</u>
	11. Total time (years) spent in this occupation	<u>**</u>

12. BIRTHPLACE (city or town) Tallahassee, Florida
(State or country)13. NAME Daniel S. Fisher14. BIRTHPLACE (city or town) Georgia
(State or country)15. MAIDEN NAME Minnie Lee16. BIRTHPLACE (city or town) Georgia
(State or country)17. INFORMANT Robert H. Wheeler
(Address) Charles & Woodbrook Lane18. BURIAL, CREMATION, OR REMOVAL Burial
Place Myrtle Cemetery Date Oct. 16, 1948
Tampa, Florida19. UNDERTAKER Henry W. Means & Son
(Address) 801 N. Calvert St., Balt. Md.20. FILED 10-13, 1948 C. W. Blitch
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Oct 12, 1948
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from July, 1946, to 12 Oct, 1948I last saw h. alive on Oct, 1948; death is said to have occurred on the date stated above, at 3 A.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

<u>Coronary Occlusion</u>	Date of onset <u>1946</u>
<u>Arterio-sclerotic Coronary Disease</u>	<u>1946</u>

Other Contributory Causes of importance:

Name of operation none Date of _____
What last confirmed diagnosis? _____ Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of Injury _____, 19____

Where did injury occur? _____
(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) E. Charles H. Peier M. D.(Address) 6701 York Rd Balt. Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
------------------------	---------------

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10273

44

1. PLACE OF DEATH

County Balto.
 City or town Essey Mad.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Essey
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1 North Stuart Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Eric L Whitney

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Y6.(b) Name of husband or wife Elta

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 41 Months 1907 Days 1 If less than one day
 hrs. min.9. Birthplace Penna.
 (Town, county, and state)10. Usual occupation Supt11. Industry or business Civil Service12. Name George Whitney13. Birthplace Penna14. Maiden name Y English15. Birthplace Penn16. Informant Elta WhitneyAddress 1 N. Stuart Ave17. Burial
 (Burial, cremation, or removal. Which?)Date thereof 10-3-45
 (month) (day) (year)

Cemetery or crematory

Location Endicott N. Y.18. Funeral director L. BurchinAddress 1407 Eastern Ave Rd.19. Oct 2 19 48 A. W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 19 47 to Oct 19 48and that I last saw him LM alive on Sept. 27 19 48

Immediate cause of death

Coronary Occlusion

DURATION

1 yearDue to Arteriosclerosis 1st D.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lydon A. Green

M. D. or other

Address Medial Arts Bldg Date signed Oct 4, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10274

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, MarylandHow long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2901 Evergreen Ave.
(If rural, give LOCATION)2.(a) If veteran, name war WW-I ✓

3. (a) FULL NAME

BASIL M. WILDER

3. (b) Social Security Number

215-28-9684

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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8. (b) Name of ~~deceased~~ wife Lillian M. Wilder8. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) 7-2-95

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>3</u>	<u>9</u>	hrs. min.

9. Birthplace Homer, La.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Atwood E. Wilder13. Birthplace Genora, La14. Maiden name Bennie McCarnie15. Birthplace Homer, La.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 10/13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director Howard Blight, Jr.Address 6009 Harford Rd., Baltimore, Md.19. 10/12 1948 AW. Helms
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 19 48 at 1:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 6, 19 48 to October 11, 19 48 and that I last saw him alive on October 11, 19 48Immediate cause of death Cerebral Hemorrhage DURATION 1 day

Due to

Due to

Other conditions Cirrhosis of liver 6 mos. plus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH

H.C. MANAUGH, M.D. Chief Prob. Ser.

Address VAH, Ft. Howard, Md. Date signed 10-11-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10275

Reg. Diat. No. 38

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Albert Wilson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Katherine Wilson

7. Birth date of deceased (mo., day, yr.)

May 19, 1893

8. AGE:

55

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Towson Md.
(Town, county, and state)

10. Usual occupation

Janitor

11. Industry or business

MOTHER

FATHER

12. Name

Albert H Wilson

13. Birthplace

Catonsville Md.

14. Maiden name

May Gibson

15. Birthplace

Eastern Shore Md.

16. Informant

Benjamin Wilson

Address

4410 E. Penna. Ave.

17. Burial

(Burial, cremation, or removal) Which?

Date thereon

Oct. 13, 1948
(month) (day) (year)

Cemetery or crematory

Pleasant Rest Cem.

Location

Towson, Md.

18. Funeral director

Mrs Kate R. Williams

Address

322 N. Schroeder St.

19.

10/12

19

48AD. Hedrick

Registrar

on

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

437 E. Penna. Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 10, 1948 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19... to... 19...
and that I last saw him alive on... 19...

Immediate cause of death

Acute congestive heart failure

DURATION

Sudden

Due to

Alcoholism-chronic and probably acute1 yr. approx.

Due to

Other conditions

Arteriosclerosis
Probable chronic myocarditis
(Include pregnancy within 3 months of death)unk
unk

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Hudson M.D. D.M.E.
M. D. or other

Address

Towson Md

Date signed

10/10/48

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10276

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

703 I St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BallsCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 703 I St.
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Louis Wyatt

3. (b) Social Security Number

219-03-6432

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ruby Wyatt

7. Birth date of deceased (mo., day, yr.)

December 25, 18706. (c) If alive, give age 45 years

8. AGE:

Years 77Months 9Days 5

If less than one day

hrs. min.

9. Birthplace

Smithfield, Va.
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Steel Mill

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Ruby Wyatt

Address

703 I St.

17.

Buried
(Burial, cremation, or removal, Which?)

Date thereof

Oct 4, 1948
(month) (day) (year)

Cemetery or crematory

Ebenezer Cemetery

Location

Smithfield, Va.

18. Funeral director

Samuel W. Sullivan, Jr.

Address

1011 N. Arlington Ave., Ball, Md.

19.

Oct 1 - 48
(Date rec'd by registrar)Dawson L. Harber

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 48 at 4 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May19 48to Oct 119 48and that I last saw him alive on September 26 19 48

Immediate cause of death

Cardio-respiratory failure

DURATION

2 days

Due to

Chyranition due to generalized2 mos.

Due to

carcinomatosis

Due to

carcinoma of stomachindefinite

Other conditions

Chronic Arthritis10 years

(Include pregnancy within 3 months of death)

Major findings of operations

-Date of op. -

Autopsy results

-

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert E. Fairer MD

M. D. number

Address

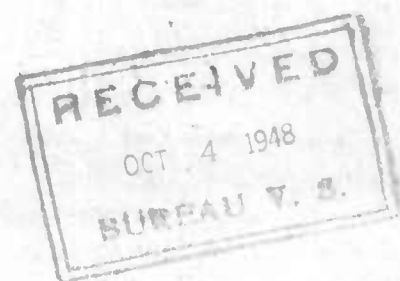
Sparrows Point, MdDate signed 10-1-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10277

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 Days

Hospital, institution, or street address where death occurred:

VAH, FT. Howard, MarylandHow long in hospital or institution? 37 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 S. Stricker Street
(If rural, give LOCATION)2.(a) If veteran, name war WW -2 ✓

3. (a) FULL NAME

CLINTON D. ZIEGLER

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.)

7-1-1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

50319

hrs.

(1)

Uremia, due to #3 Other conditions6 Mos.9. Birthplace Cozeytown, Pennsylvania
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER

12. Name Harvey Ziegler13. Birthplace Pennsylvania

MOTHER

14. Maiden name Fannie Martsburger15. Birthplace Pennsylvania16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

17.

BurialDate thereof 10 22 48
(month) (day) (year)Cemetery or crematory Baltimore National Cemetery
Baltimore, Md.

Location

18. Funeral director

Howard Blight Howard M. Blight

Address

6009 Harford Rd., Balto., Md.

19.

10/21 19 48
(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1948 at 1:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13, 1948 to October 20, 1948 and that I last saw him alive on October 20, 1948

Immediate cause of death

DURATION

(1) Uremia, due to #3 Other conditions 6 Mos.

Due to

Due to

Other conditions (2) Hypertensive cardio-vascular disease; auricular fibrillation decompensation; (3) Nephrosclerosis, secondary to #2 Duration: About 6 yrs.

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, publc place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH
H.C. MANAUGH, M.D. Chief Pro^d. or Ser.Address VAH, Ft. Howard, Md. Date signed 10-20-48